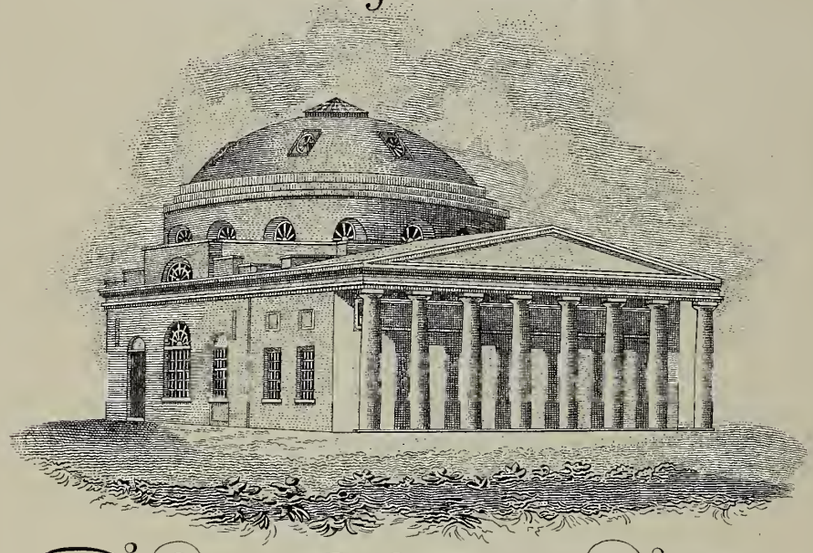
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January 1950 ★ VOLUME 46 ★ NUMBER 1

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The Ohio State MEDICAL JOURNAL

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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

The Psyche Is the Thing Today

IT was to be expected that with the load which we of this generation have been called upon to carry in our time, we should worry about our minds and wonder how they work. People of my generation have had to adjust their lives to the automobile, the airplane, Sunday comics, a World War with gas as a new weapon, installment-payment purchases, radio, mechanical refrigerators, another global war with its atomic bombs and long-distance planes and a threatened biological warfare, sulpha drugs and the antibiotics, television in black and white and now in colors.

As a result, in the World War II and the subsequent years, great advances were made in knowledge of the causes of mental illness, in improvement in methods of treatment, and in the development of more effective organization for prevention.

The Commonwealth Fund has made available an excellent book, **Mental Health in Modern Society,** by Thomas A. C. Rennie, M.D., and Luther E. Woodward, Ph.D. ($4.00. *The Commonwealth Fund, New York City),* presenting the contemporary thoughts in the field of mental hygiene.

Your reviewer is deeply impressed that our experts on mental illness spend much time recording the vagaries of a mind that is not working right in an attempt to find the precipitating cause of the functional failure but not a minute in an attempt to get at the primary cause.

It has been my contention (see **Soil, Food and Health,** $4.50. *Friends of the Land, Columbus, Ohio,* August, 1949, issue O.S.M.J.) that back of all these brain malfunctions is a bad state of nutrition, both in the patient and in his parents. Ralph Borsodi, one of the greatest modern philosophers, has written a clear explanation of the impact of modern living on the human mind. **(Living and Education,** by Ralph Borsodi, $10.00. Four Volumes. *Devin-Adair Company, New York City.)* He insists that our failure to adjust ourselves to this world of gadgets is based upon a system of miseducation. "What we should have been asking at all steps," Borsodi says, "is, 'Is this within the "biological norm" for Man?' " He supplies us the criterion for determining whether it is or is not.

A number of "success" books have cashed in on this modern trend in reading. Several have been best sellers for several months now. A third edition of **Character Analysis** by Wilhelm Reich, translated by Theodore Wolfe ($6.00. *Orgone Institute Press, New York City),* has appeared with a jargon all of its own. It is very confusing to the average reader and I am sure no busy physician will find time to acquaint himself with its ideas. On the other hand, **Successful Living,** by W. Beran Wolfe, M.D. ($1.00. *Blue Ribbon Books, Garden City, New York),* is a reprint of a book designed to give practical advice in the conduct of this problem of everyday life. It is a practical approach in that it asks the reader "to address himself to the artistic problems of fulfilling his destiny as the master of his own soul and the captain of his life." This means that he will do something decisive about the problem, if he can. If he recognizes that the problem is too big for him then he reasons that such problems are in the hands of destiny and he develops an attitude of trust towards his Maker.

It seems certain that the real peril to our Western civilization lies not in the atomic bomb or in Russian aggression, but in the way our people have succumbed to a feeling of insecurity and confusion. William G. Niederland, M.D. **(Man-Made Plague**—a Primer on Neurosis, $3.50. *Renbayle House, Publishers, New York City),* has pointed out the astounding amount of prejudice, hatred, superstition, fear, and bad logic the average individual harbors in his mind. While all of this is well known today, it makes no impact upon the average mind. In our modern system of miseducation, as Borsodi has said so many times, our students complete eight years of so-called higher education in law, medicine, sociology, education, and engineering without ever becoming aware of the significance of these facts. Here is one authority who recognizes the close connection between physical and mental health.

Whether mental hygiene has a place in the work of the public health officer is very debatable, but that it has a place in the work of the teacher and the physician there can be no doubt. That mental hygiene has a place in preventive medicine, there can be no doubt, and in all considerations of the health of the public. Fundamentally, it is a personal problem and a personal responsibility since it is not communicable. So while I can quarrel with the title, I can also warmly recommend Dr. Paul V. Lemkau's new book **(Mental Hygiene in Public Health,** $4.50.

McGraw-Hill Book Company, New York City) to teachers and physicians. My quarrel is that teaching should be done in our schools by persons who are trained teachers—else there is no excuse for our college of education.

Speaking of what was learned about mental disease and mental hygiene during the last war, William C. Menninger has attempted to revise the evolution of psychiatric practice in the Army, where as you know, to the disgrace of our civilization, it was necessary to promote it to first place. **(Psychiatry in a Troubled World** by William C. Menninger, M.D., $6.00. *The Macmillan Company, New York City.)* The second part of this book has been written to help any person get along with other people. It represents the author's idea of the possible contribution psychiatry can make to social experiences of all kinds.

In spite of the abundance of literature concerning the diagnosis, pathology, and therapy of compulsion neurosis, we still are confused by the divergence of opinion in this field. While a large group of authorities of the old school consider obsessional desires as organic brain disturbances and compulsion neurosis as a form of insanity or degeneration, some writers, even as far back as the Nineteenth Century, were able to recognize compulsion neurosis as a disease *sui generis* and generally differentiated it from psychosis. A translation of Wilhelm Stekel's **Zwang und Zweifel** has been made by Emil Gutheil, M.D. **(Compulsion and Doubt,** $7.50. Two Volumes. *Liveright Publishing Corp., New York City),* in the effort to show more light upon the problem of obsession-compulsion disorders.

He insists that obsessions are obtrusive ideas which the patient considers "ego-foreign" and which he vainly attempts to renounce.

Compulsions included various acts executed as a result of irresistible impulses. The patient himself may consider these acts nonsensical or alogical, yet he is forced to comply with his impulses because of his fear of an impending disaster. The therapy—analysis, of course.

The collector and the student of psychiatry who wishes to get a historical prospective will enjoy Robert Fliess' book **(The Psychoanalytic Reader,** $7.50. *International Universities Press, Inc., New York City)* which is an anthology of essential papers with critical introductions.

It is now fifty-six years since Freud began the publishing of his work which started a new method of treating illness. To bring us up to date and to evaluate what has happened in these six decades, Sandor Lorand, M.D., has called upon some thirty well-known Freudians to help him. **(Psychoanalysis Today,** $6.00. *International Universities Press, Inc., New York City.)*

Modern man, aware of this lack of consciousness of the complicated arrangements upon which science has to rely in order to gain valid data, has relinquished the exercise of his function of judgment in scientific questions to a small number of highly specialized experts. He would, consequently, not think of challenging the validity of a chemical formula, the existence of a physiological process, or the aptness of hypothetical concepts in physics on the grounds that they failed to appeal to his imagination or interfered with his personal preconceptions. To put it briefly, in an age when neither imaginability nor compliance with general prejudice are any longer criteria for the validity of a scientific conclusion, the "naïve" observer has become obsolete and the "trained" observer has taken his place. This is the defense of the Freudians and the Christian Scientists, as well, both of whom refuse to allow me to call my soul my own. So, a "naïve" observer like your reviewer welcomes this anthology and all the more this last book and its attempt to evaluate what the Freudian school has accomplished.

Then, there is the writer, E. Pickworth Farrow **(Psychoanalyze Yourself,** $3.25. Second revised edition. *International Universities Press, Inc., New York City),* who attempts to show us how to remove unreasonable fears and depressions from our minds. Of him, Freud has written, He "is known to me as a man of strong and independent intelligence who, probably on account of a certain willfulness of character, could not get on well with the two analysts with whom he experimented. He then had recourse to a consistent application of the process of self-analysis which I had once used myself in order to analyze my own dreams. His results deserve notice, especially because of his special individuality and his technique."

In an attempt to show what the physician can do for his patients, Dr. Ludwig Eidelberg has written a popular book. **(Take Off Your Mask,** $3.25. *International Universities Press, Inc., New York City.)* The Doctor has done this because "in the last few years, more people want to know more about the mysterious instincts which cause us to love and hate. They want to understand those parts of the personality that control and direct these instincts." With new names "id," "ego," and "super ego," we have a scientific(?) description done much in the spirit of the old class-leader in the Orthodox Methodist Episcopal Country Church which I attended in my youth. But instead of the testimonial technique of confessing his sins and testifying for Jesus and glory on account of his simple soul and "the still small voice," the modern introduce the "couch and confidence" technique. Dr. Eidelberg explains the new advancement in hypnotic technique. He tells what happens to the analyst back on his chair and to the patient on his analytical couch when he begins to tell

what is going through his mind. But the author urges you not to try it on yourself—it is dangerous, he says.

To keep his followers up to date, Sandor Lorand, M.D., together with an equally distinguished editorial board, produces each year **The Yearbook of Psychoanalysis** ($7.50. Volume Four. *International Universities Press, Inc., New York City.)* It contains this year some 23 essays on various phases of the practice.

The day has passed when psychiatry suffered from inattention. It now occupies the center of the stage. Melvin W. Thorner, M.D., assistant professor of neurology in the graduate school of the University of Pennsylvania, is much disturbed because so many of us physicians look upon psychiatry as a strong cult built upon a vain attempt to diagnose on the basis of multiple records of the vagaries of a sick brain and no organic pathology. He is as much embarrassed as we are discouraged by the strange point of view and elaborate jargon—both foreign to the rest of the medical profession—which has grown up around the subject.

To an astonishing degree the author of this book has overcome the language barrier. He has presented the subject in a way that is both interesting and understandable. **(Psychiatry in General Practice.** $8.00. *W. B. Saunders Company, Philadelphia.)*

He recognizes that psychiatry is still a specialty in the making, only now accumulating data that have a basis in scientific determination. Only now, descriptive diagnosis of mental diseases are being replaced by established disease entities. In other words, it lags a hundred and fifty years behind other fields. But this book, because it makes complicated things simple, gives us in general medicine a good deal of help in lieu of actual experience with patients.

To help us in general medicine, the Staff at Columbia-Presbyterian Medical Center has attempted to bring psychiatry seventy-five years nearer by following the plan introduced in 1890 by William Osler. **Synopsis of Psychosomatic Diagnosis and Treatment,** by Flanders Dunbar and Staff ($6.50. *C. V. Mosby Company, St. Louis, Missouri),* is a fine addition to the physician's library because it goes over each system by system.

It is just six years ago that Weiss and English brought out the first edition of their larger volume of **Psychosomatic Medicine.** Now they come with a second edition ($9.50. *W. B. Saunders Company, Philadelphia.)* In the meantime, the concept behind this book has gained wide acceptance. It contains much new material on diagnosis, on social work, and many new illustrative cases.

Our own Joseph L. Fetterman gave a series of lectures to student officers of the school of military neuropsychiatry during 1943 and 1944, and a series of seminars in Cleveland in 1945 and 1946. This material he has also assembled into a book **(Practical Lessons in Psychiatry,** $5.75. *C. C. Thomas, Springfield, Illinois),* in the hopes that it will help towards a better understanding of the common conditions.

There is, it is said, one or more incipient cases of mental disturbance in every family circle as well as one more advanced case. These lighter cases are often overlooked both by the family and their physician. To recognize these and thus take an immense load off the backs of the medical profession and to empty as many as 25 per cent of our hospital beds, Benzion Liber, M. D., has written a popular book, **Psychiatry for the Millions.** ($2.95. *Frederick Fell, Inc, New York City.)* Such efforts should stimulate more medical men to recognize incipient psychoses and see the connection between mental and physical ills.

To explain **The Re-Creating of the Individual,** Dr. Beatrice M. Hinkle has reissued her book by that title. ($5.00. *Dodd, Mead and Company, New York City.)* Wherever we touch upon the current of American thought these days, we find the same impelling force: Flight from personality responsibility; an avoidance of risk and romance of endeavor; a mad urge for submergence into the group where, it is believed, the certainty and regularity of existence will be achieved. It is this promise of relief from this obligation, this escape from personal responsibility that is the real lure of socialized medicine.

Dr. Hinkle's book is an attempt to get away from this infantile wish and to help us develop intellectual maturity. "The gaining of a true meaning in life and the need of the individual to become conscious of his personal responsibility for himself and to fix his own direction, is an imperative necessity for many persons today."

The work is truly inspirational and points the direction to the greatest happiness that man can experience—to develop his own human dignity to the point where he will have regard for the human dignity of all others.

One of the most helpful books which I have read in this field is **Everyday Psychiatry,** by John D. Campbell, M.D. ($6.00. *J. B. Lippincott Company, Philadelphia),* now in its second edition with several new chapters as well as such revisions as time and constructive criticism could offer.

It is a practical book which gives the physician not specializing in this field, a comprehensive outline that leads to understanding.

A book that is almost a best seller is **Conditioned Reflex Therapy** by Andrew Salter ($3.75. *Creative Age Press, New York City).* This book makes a direct approach to the reconstruction of a personality by following virtually in the path of Pavlov and other great neuro-

physiologists. "All the highest neurosis activity, as it manifests itself in the conditioned reflex, consists of a continual change of three fundamental processes—excitation, inhibition, and disinhibition." This approach makes sense to a biologist. The appearance of this book marks the beginning of sense in psychiatry rather than the classification of the vagaries of sick brains.

Most physicians have not tried to interest themselves in an attempt to understand the psychological disorders or their relationship to bodily upsets. Yet unfavorable psychological factors are a component of the unfavorable forces that break down the resistance of our total personality. This breakdown is definitive of DIS-ease.

We physicians have not even tried to listen to the jargon of the psychiatrists. As practical men we have noted all too often that the specialist was himself a maladjusted individual who was trying to escape from himself by projecting himself to his patients. In other words, all too frequently, it is self-evident that this psychiatrist is a misfit who enjoys sticking his nose into other people's business because he cannot manage his own.

The general trend of the books covered in this review, however, points to a new day when the biology of the psyche will dominate. The crying shame for the sick and the near-sick is that effective psychotherapy has been neglected.

A large part of this form of treatment is neither mysterious nor difficult. By following certain simple principles, any physician can better the state of mind of a high proportion of his patients. For, after all, there are but three things that a person can do about things which are upsetting him emotionally. He can calm down and with the help of his pastor and his physician can recognize the nature and magnitude of his problem. He can then go ahead in a matter-of-fact sort-of-way and solve it. Or, he may recognize his problem is not his responsibility and he is not going to be able to solve it. Then he can secure the help of his God to bear his cross and be all the greater and kinder a personality for it. Or, lastly, he can do what more than half of the people are doing in this country today, viz., wring his hands and keep saying "What shall I do? What shall I do?"

If the factor is removable, like the fear of a grave disease, this can be solved easily by the forceful physician. Or as we specialists are prone to do, the mistake may be made of fixing the patient's mind on some special organ and so hysteria is often developed. The whole subject of psychotherapy may be defined as maintaining the reassuring attitude of sympathetic understanding. It has a wide application in medicine.

The essential basis of this psychotherapy for the hysteria is to put the burden of recovery on the patient himself. In doing so, the attitude adopted must be unsympathetic, whereas in the patient who is only emotionally upset, this attitude must be sympathetic and understanding. All of this the old family doctor knows and practices.

Hematology, by Willis M. Fowler, M. D. ($8.50. Second Revised Edition. *Paul B. Hoeber, Inc., New York City)*, presents the problems in its field in a form that will meet the needs of the medical student and his elders in medicine.

How To Become a Doctor, by George R. Moon, M. A., ($2.00. *Blakiston Company, Philadelphia, Pennsylvania)*, is a book of advice to those young persons who think that they want to practice applied biologic science in the healing fields—physician, dentist, veterinarian, pharmacist, chiropodist, occupational therapist, hospital administrator, medical illustrator and biological scientist. It is the most complete discussion of the problems of finances, housing, outside employment, internships, and residencies. The advice is based upon twenty years as a registrar and a member of an admission committee of a medical faculty.

Atlas of Obstetric Technic, by Paul Titus, M. D., ($7.50. Second edition. *C. V. Mosby Company, St. Louis, Missouri)*, is an excellent example of visual educational material. The material has been rearranged in some instances into a better working sequence and modernized throughout. The illustrations are by Shackleford of Pittsburg.

A Baby Is Born—The Story of How Life Begins, by Milton I. Levine, M. D., and Jean H. Seligmann ($1.50. *Simon and Schuster, Inc., New York)*, looks like most of the other storybooks for youngsters and so could be laid out for the time when curiosity has been aroused enough to ask or look in it. It is a sound text with clever illustrations by Eloise Wilkin.

The 1949 Year Book of Medicine, edited by Beeson, Amberson, Minot, Castle, Harrison and Eusterman ($4.50. *The Year Book Publishers, Chicago, Illinois)*, maintains the high standards that have characterized this work for years. It makes one of the handiest places to review the happenings of the past twelve months rapidly. Your reviewer would not think of being without it.

A Study of Institutional Children with Particular Reference to the Caloric Value As Well As Other Factors of the Dietary, by P. B. Mack and Charles Urbach *(Monographs of the Society for Research in Child Development, Serial No. 46, Volume XIII, No. 1. National Research, Washington 25, D. C.)*, recites the improvements in 234 children as their diets were improved over a period of two years.



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JONATHAN FORMAN, M. D., *Editor*

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Current Trends in the Treatment of Hernia

FRANK GLENN, M. D.

THE incidence of hernia in our population apparently remains constant. It is commonly held that in each 125 male births there will be one with a congenital hernia.[1] Though many of these hernias spontaneously recede, they may recur during the period of robust activity in early adult life. Therefore, it follows that the repair of a hernia remains one of the most frequent operations performed. On the surgical service of The New York Hospital —Cornell Medical Center, for example, almost 4,000 hernia operations have been performed over a period of sixteen years, from 1932 to 1948. This is an average of about 230 a year. In other words, an operation for hernia is done on almost every operating day during the year, and I believe that in many hospitals hernia repair constitutes an even greater proportion of the total number of operations performed.

In general, it may be said that the results of hernia repair have been highly satisfactory over the past fifty years. This has been particularly true for the congenital indirect inguinal hernia in the young adult. However, the direct hernia found particularly in the older age group, and the recurrent hernia have always been, and continue to remain, problems that require the best of surgical effort. Although the inguinal type is found most frequently, there are other types of equal importance which often constitute problems of greater magnitude. In our own experience they range as follows:

Presented before the Section on Surgery at the Annual Meeting of the Ohio State Medical Association, Columbus, April 19-22, 1949.

The Author

● Dr. Glenn, New York City, N. Y., is a graduate of Washington University School of Medicine, 1927; member, American Surgical Association, Society of University Surgeons, and Society of Clinical Surgery; surgeon-in-chief, New York Hospital; and professor of surgery, Cornell University Medical College.

HERNIA REPAIR
New York Hospital 1932-1948

Year	Inguinal	Ventral	Femoral	Epigastric	Umbilical	Diaphrag.	Misc.	Total	
1932 (a)	154	23	7	5	4	1	1	195	
1933 (a)	209	25	10	5	10	5	7	271	
1934 (b)	29	19	3	1	4	–	17	73	(b)
1935	140	24	6	4	11	–	6	191	
1936	73	17	12	1	9	–	7	119	
1937	104	15	11	–	4	–	15	149	
1938	155	14	14	2	12	–	16	214	
1939	155	36	16	–	9	2	19	237	
1940	184	33	19	–	11	1	22	270	
1941	180	28	20	1	7	1	18	255	
1942	223	24	25	4	10	1	—	287	
1943	240	22	24	2	17	1	10	316	
1944	201	21	12	1	18	1	—	254	
1945	179	—	17	8	22	2	9	237	
1946	198	—	15	16	23	2	11	265	
1947	218	20	37	–	21		5	301	
1948	219	32	20	8	16	2	—	297	
TOTAL	2,861	354	268	58	208	19	163	3,931	

(a) Sept. 1 to Aug. 31
(b) Four months only: Sept. 1 to Dec. 31
Thereafter calendar year is used.

This table gives the over-all numerical incidence as to type, but does not indicate the group of patients that require special attention. Such a group includes the long-standing and neglected

hernia, the recurrent hernia, the large ventral hernia that contains many of the abdominal viscera, and the acute hernia that is often associated with intestinal obstruction. Then there is the diaphragmatic hernia which frequently causes severe symptoms in the older patients or debilitated individuals. These variations are brought to your attention because many questions remain unanswered in treating these groups.

In reviewing the reported experience of various clinics throughout the country, it is evident that continual progress is being made in the management of the patient with a hernia. Through prolonged follow-up studies, past inadequacies of treatment have been brought to light and new measures devised to correct them. One can say that over the past thirty years several trends in treatment have developed that account for a lower morbidity of complications and a decreasing incidence of recurrence. These trends are the result of more meticulous handling of all structures at the time of operation, the use of finer suture material, more accurate approximation of structures without tension, better preoperative preparation, more selective anesthesia, closer attention to metabolic requirements following operation, earlier postoperative mobilization, and, in certain instances, chemotherapy.

TRENDS AS TO WHICH PATIENTS SHOULD BE OPERATED UPON

There is a tendency now to operate on children at an earlier age than previously. This has been reported from the Boston Children's Hospital[2] and by other clinics. Infants with a congenital hernia that allows entrance of viscera into the sac, are now being treated by two methods.

By the first, using local anesthesia, the sac is dissected free from the cord and ligated at its neck. No attempt at repair of the abdominal wall is made other than to replace the structures in their proper anatomical relationship. This procedure when done with meticulous care has resulted in a very low incidence of testicle atrophy, one of the chief objections to the operations voiced by the textbooks on surgery. Following this repair, these children are kept in the hospital only a very short time and are then brought back to have their sutures removed after the usual interval.

The second method is the revival of an old procedure that was used in many of the European clinics around the turn of the century. This consists of exposing the neck of the sac under local anesthesia, dissecting the cord from the sac, and then ligating the sac with a simple ligature. This procedure has been recently reported as an ambulatory treatment with satisfactory results, but follow-up statistics are not yet available for critical evaluation of this method.

At the other end of the life scale, in the older age group, there has been an increase in the operative attack on hernia. Several factors account for this. First of all, the number and proportion of individuals over sixty years of age has increased sharply over the past thirty years. In this group hernias are associated with debilitation and those changes that may produce increased intra-abdominal pressure. There are also those who have tolerated a hernia over a number of years, but with increased age lose muscular tone which permits small hernial defects to become enlarged and allows additional abdominal viscera to escape into the sac, with symptoms that may be anything from annoying to intolerable.

There are thus more older people with hernia, but improvements in the administration of anesthesia and the management of geriatrical problems in general have rendered few of these patients inoperable. This holds true for all types of hernia, including the diaphragmatic and large postoperative ventral.

Between these two extremes of life are the hernias that appear among the more active members of our population. In recent years there has been a tendency to bring a greater number of these individuals to operation as soon as a hernia is discovered. Such practice has been materially fostered by the compensation panels and industrial insurance groups.

SHOULD THE PATIENT WITH A LARGE OR PROMINENT EXTERNAL RING BE SUBJECTED TO OPERATION?

The compensation and insurance groups, however, are partly responsible for another trend that is open to question. A physician who examines patients for an industrial organization looks for "potential" hernias as well as actual. Should he discover a hernia, it is to the advantage of the company as well as the patient that it be repaired before the employee is put on the payroll. Of this there is no question. However, when the same physician finds an external ring that is larger than usual, more often than not he recommends repair of the "potential" hernia. The patient often has had no symptoms of hernia, careful examination shows that he has none of the classical findings of hernia, and at operation no hernia is found, but following the operation the patient is eligible for employment. Certainly it is questionable whether he has benefited by the operation, and indeed, he may develop a "recurrent" hernia later that might not occur if the first operation had not been done.

An external ring may be larger than average, and if so an impulse on coughing may be felt. But this may also be the case in the average

or normal ring and does not demonstrate a hernia. A sac or a projection of the peritoneal cavity must exist if a hernia is present. Sometimes a patient may have a history of symptoms and manifestations of hernia and yet on examination, a sac cannot be demonstrated, even though an enlargement of the structural mass of the cord that does not continue down the extent of the cord in many cases can be palpated just distal to the external ring.

It is therefore our contention that patients with no demonstrable hernia and without a history suggesting hernia should not be operated upon. Far too many "potential" hernias are subjected to operation, and the process of seeking to demonstrate a hernia at operation may result in so distorting and weakening the structures in this region that a recurrence is likely to occur subsequently.

TRENDS IN ANESTHESIA

Great strides have been made in anesthesia over the last two decades, and the range of anesthetic agents open to selection for hernial repair has greatly increased. The administration of anesthesia has become much more efficient, with the result that the incidence of postoperative complications with hernia has been markedly reduced.

In our own experience over a five-year period from 1940 to 1944,[3] in a group of 1,385 consecutive cases on whom 1,545 hernias were repaired, there were 13 instances of atelectasis, five of pneumonia, and eight of pulmonary infarction. These we group under postoperative pulmonary infections incurred principally as a result of anesthesia. Coronary occlusion occurred twice and was fatal in one instance. It is our opinion that early mobilization is also contributing to the decrease in pulmonary complications commonly ascribed to anesthesia.

Even twenty years ago there was a distinct trend toward local anesthesia, which is particularly suitable for the majority of hernias. On the other hand, many still insist on spinal anesthesia because it produces more complete relaxation and hence consider it more satisfactory when handling the deeper structures. In general there can be little to argue with the adequacy of this type of anesthesia, but there are occasional untoward reactions following its use. Some patients require a general anesthesia and for these ether, nitrous oxide and oxygen, cyclopropane, and other inhalation anesthetic agents are highly satisfactory. In our clinic we have found that a local anesthesia supplemented with pentothal drip has recently gained in popularity both with the staff and the patients. For the repair of subdiaphragmatic hernias, closed system inhalation provides an anesthesia for the intrathoracic approach that has much to recommend it.

Hernia repair in children in our experience has not been satisfactorily handled under local anesthesia, and so we have come to use general anesthesia in some form. Of course this operation does not require profound muscular relaxation and thus light stages of surgical anesthesia are sufficient. It is our feeling that the open drop ether technique for infants is by far the safest in most hands. During the administration of open drop ether a large flow of oxygen is run beneath the mask so that the oxygen saturation will be within normal limits and the carbon dioxide saturation is reduced to a sufficiently low point to prevent hyperventilation, a complication of anesthesia administration. Preoperative medication consists of a dose of atropine suitable for the age and weight of the child, together with an appropriate dose of phenobarbital or morphine.

Dr. Digby Leigh,[4] one of the outstanding pediatric anesthesiologists, of Vancouver, Canada, feels that children should have a suitable dose of morphine medication combined with atropine or scopolamine. He believes that these children under anesthesia have an exhaustingly rapid respiratory rate and tachycardia. Since some of the large hernias in infants may take a considerable amount of time to repair, the exhausting respiratory and cardiac rate tends to be fatiguing. Morphine premedication counteracts these effects and helps maintain a more normal respiration and cardiac rate. Premedication should always be given subcutaneously an hour to an hour and a half before anesthesia is started. We also recommend a cut-down with appropriate fluid therapy if it is anticipated that the procedure will last over an hour and a half.

When we reported the repair of 1,545 hernias in 1947,[3] we listed the types of anesthesia used as follows:

Local	1,090
General	397
Local and general	37
Spinal	21

Since then there has been an increase in the use of local anesthesia supplemented with pentothal and a decrease in the use of general anesthesia alone. This is particularly true for inguinal hernia operations.

METHODS OF REPAIR

For the simple, uncomplicated, indirect inguinal hernia, the regular anatomical hernial repair is adequate. This provides for removal of the sac with high ligation, and reconstruction of the normal anatomical relationships of the abdominal wall structures.

For the older patient, or for the individual with a large indirect inguinal hernia, transplan-

tation of the cord external to the internal oblique and beneath the external oblique, as described by Bassini,[5] is an adequate repair. But these patients and those with a direct inquinal hernia are probably better protected from recurrence by the Halsted method.[6] This provides for transplantation of the cord to the subcutaneous tissue, thus avoiding a critical angle near the pubic spine, through which recurrences commonly take place.

In addition to these three methods, which are the ones most commonly employed today, numerous modifications have been developed that have become popular during the past ten years.

One of the most recent of these is the utilization of Cooper's ligament as advocated by McVay.[7] He has reported his experience with 100 inguinal and femoral hernioplasties without a recurrence in a one-to-nine year follow-up.

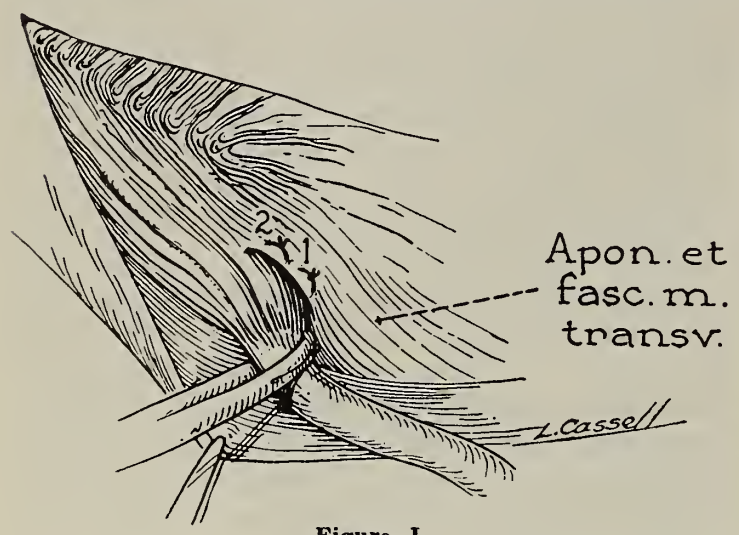


Figure 1

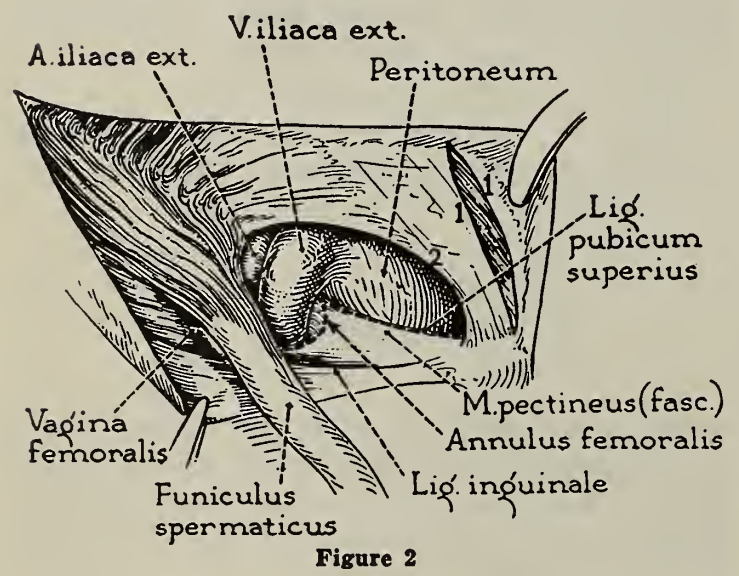


Figure 2

His illustrations are distinctive and might be copied. They emphasize three points:

(1) In the small, simple, indirect hernia, the sac is excised and the slightly dilated abdominal ring is closed snugly medial to the cord, using the aponeurosis of the transversalis fascia. Nothing additional is done.

(2) For the larger hernia, with a weakened wall, Cooper's ligament is used to bring the fascia over and secure it up to the iliac vein. To facilitate this, a relaxing (Rienhoff) incision is used.

(3) The external oblique is replaced, permitting the cord to exit through the external ring, which leaves the structure in a more normal position.

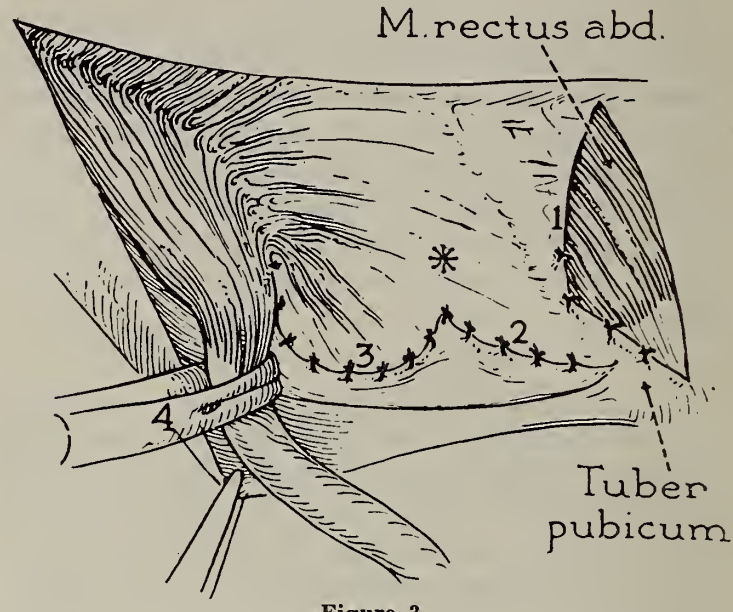


Figure 3

Fig. 3.—The reconstruction is complete. The previously incised transversus stratum has been sutured to Cooper's ligament from pubic tubercle to femoral vein (2) and then to the anterior femoral sheath (3). The cord has been pulled laterally (4) to demonstrate the closure of the abdominal inguinal ring. The relaxing incision is now a triangular defect, and the lateral margin has been sutured to the underlying tendon of the rectus abdominal muscle. The spermatic cord is dropped in against the new posterior inguinal wall and the external oblique aponeurosis closed over it with the subcutaneous inguinal ring in the normal position.

The author's contribution lies in his reconstruction of the posterior inguinal wall in large indirect, direct, and femoral hernias.

In a more recent article, McVay[8] has presented in detail a single operative procedure for the repair of large indirect, direct, and femoral hernias. This operation consists essentially of restoring the inguinofemoral anatomy to its normal status. Repair is similar for all three types because the three represent defects in the same layer at different points.

Since there is no anatomic defect in the inguinofemoral region in the uncomplicated small indirect inguinal hernia other than the presence of a congenital hernial sac and a slight dilatation of the abdominal inguinal ring, it is recommended that this type of hernia be repaired by removal of the sac by accepted methods and by subsequent tightening of the abdominal inguinal ring.

Harkins and Schug[9] reports 294 patients with 367 operations for inguinal hernia. Their policy is to employ Cooper's ligament instead of Poupart's, and to secure the structures to it. They follow the recommendations of McVay and Anson and employ silk sutures throughout. It is their general policy to keep the patient in bed at rest

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Illustrations reprinted with permission from an article by Chester B. McVay, M.D., *Surgery, Gynecology and Obstetrics*, April, 1949.

for about twelve days for a simple unilateral hernia, fifteen days for bilateral, and nineteen days for recurrent. During the past two years, however, all patients have been gotten out of bed within twenty-four hours after operation. The recurrence rate has been 2.3 per cent for cases followed over two years.

As to the repair itself, Harkins and his group have used the transversalis fascia when it appeared strong enough, but if inadequate, the internal oblique aponeurosis has been included as well. Fixation of these structures to Cooper's ligament instead of Poupart's is, in their opinion, the procedure of choice for the repair of inguinal hernia.

Zimmerman,[10] in a recent editorial in *Surgery, Gynecology and Obstetrics*, offers the following objections to the McVay procedure for inguinal hernia. First, the inguinal ligament is not a fixed structure since it is suspended between two points, being attached to the fascial lata of the thigh. Secondly, the operation is not an easy one and there is a greater likelihood of thrombosis of the femoral vein. He concludes that this new procedure will not replace the old in which the inguinal ligament is used because of the greater difficulties in its accomplishment.

A slight variation of the McVay procedure has been reported by Clark and Hashimoto[11] of Salt Lake City. They report a series of 162 consecutive hernia cases in which the various structures in the region of the pubic spine have been used. These include Henle's ligament, the iliopubic tract, the aponeurosis transversus abdominis, and Cooper's ligament. It is doubtful if all of these structures are often required to secure a satisfactory repair, but it is well to keep in mind their relationship to the common site of recurrence. Also, since these structures vary as do all those that are customarily used in hernial repair, it would seem unwise to advocate this or any other method as a fixed routine.

Recently there has been considerable emphasis in the surgical literature on the premise that the surgeon has his best opportunity to cure a patient of a malignancy by complete removal of the tumor at the primary operation. This is sound teaching, and one that lends itself equally well to the treatment of hernia. At the primary operation the inguinal hernia, both direct and indirect, can be repaired with a very low incidence of recurrence. To be successful, hernia repair requires good surgical judgment and skill. It is not a minor operation and should not become the victim of any standard routine. To the careful surgical eye, no two hernias are alike. Simple obliteration of the hernial sac has long since been discarded as the only step in the surgical treatment of hernia in the adult. Meticulous reconstruction of the abdominal wall to approach anatomical perfection is equally important. True, simple high ligation of the sac for the congenital type of hernia found in young adults may result in cure for a high percentage of patients, but anatomical restoration of the structural relationships in the inguinal canal will give these patients some insurance against the development of an inguinal hernia later in life. For the acquired hernia, more common in later life, and often the result of the individual's occupation, reconstruction of the abdominal wall is of even greater importance. If the hernia is large and the structures are weak, good surgical judgment will dictate that maximum strength to the abdominal wall may be obtained by complete closure of the lowest portion and transplantation of the cord to the subcutaneous tissues.

When repairing a hernia, a few basic principles should be kept in mind:

(1) Careful dissection to identify all structures.
(2) Evaluation of the operative findings before embarking on the repair, so as to select the operation best suited to that particular hernia.
(3) Obliteration of the sac at its neck, so that a stump does not remain.
(4) Meticulous hemostasis and gentle handling of tissues.
(5) Proper selection and use of suture material.

OPERATIVE TREATMENT OF INGUINAL HERNIA IN INFANTS AND CHILDREN

Coles[12] of New York City has expressed the opinion that because congenital hernia is in no way associated with weakness of the abdominal wall, hernia repair in infants can be accomplished by simple ligation of the sac and nothing more. Specifically, he makes a small incision to expose the cord and sac, dissects the sac free of the cord at the internal ring and transects it. The distal portion of the sac is allowed to remain. This is a very old procedure and may very well have merit. He reports a series of 186 patients as of May, 1944, of which 78 were examined from six months to six years following operation with one recurrence noted. But what is of greater significance is that testicular atrophy, the reason most commonly given for not repairing hernia in the infant age group, was not found in a single instance.

TRENDS IN CHOICE OF SUTURE MATERIAL

One cannot discuss the subject of methods of hernia repair without commenting on the type of suture material to be employed. At the New York Hospital, we employ silk suture

material except for those patients with an acute hernia associated with infection. For this group we employ catgut suture material. A few years ago, we began to use fine steel wire after the method described by Babcock, but found that our repairs were no better and that our patients occasionally complained of pain around the suture material, necessitating its removal. At the present time we use silk for all uncomplicated cases and have used cotton with equally satisfactory results.

Zollinger and Flynn[13] have reviewed a series of over 200 inguinal repairs in which cotton and catgut have been compared. They found that patients with cotton sutures have a lower daily postoperative temperature, require less narcotics, and return more quickly to normal than those in which catgut is used. These findings parallel the work done recently by Pareira[14] in his comparison of silk and catgut for hernial repair.

It would appear that at the present time, silk and cotton are the suture materials of choice, but it should be pointed out that using very fine catgut should overcome many of the objections raised against its use in the past. Originally, only No. 1 and No. 2 chromic catgut were used for repairs, which introduced considerable foreign body reaction into the wound and traumatized the structures involved as they were being placed.

The use of fascial sutures and grafts have had limited popularity, chiefly because it has been demonstrated that a careful dissection which permits accurate approximation of the structures in the immediate vicinity of the hernial defect, using silk or cotton suture material, produces better results. Harkins maintains that repair with fascial sutures or grafts is distinctly inferior to the method to which was just referred.

Garner,[15] in a report of 2,040 hernia patients from the Veterans Administration Hospital in Dayton, Ohio, has expressed the opinion that the McArthur fascial suture hernioplasty has been less effective than herniorrhaphy with silk sutures, and is decidedly inferior to the Gallie fascial suture hernioplasty. He states that they reserve the Wangensteen pedicle fascial graft operation for those patients with large defects in the fascia of the abdominal wall. He also recommends the use of silk suture material for approximating the transversalis fascia to Cooper's ligament.

There are other substances that have been lately introduced for repairing hernial defects. Scola[16] of Buffalo, New York, has reintroduced the use of a buried dermal graft. This consists of cutting an almost full thickness graft and then removing a very thin portion of the epidermis. The skin is used in the place of the structures that are more commonly employed in the repair of hernias. We have had no first-hand experience with this procedure, but we feel it might offer a real solution to the difficult recurrent cases, and that it might be as effective as fascia transplants.

Still another method has been introduced by Koontz,[17] who has used tantalum mesh in the repair of large ventral hernias in five obese patients. There has been no apparent untoward reaction of the tissue to this foreign body, but his report gives only one follow-up of eleven months, and in this patient there was some fragmentation of the mesh. The mesh is secured to the tissue with tantalum sutures.

Perhaps the most recent contribution is that proposed by Dr. John E. Sutton[18] of New York. For difficult hernial repairs, he advocates a pedicle graft of the sartorius muscle with its anterior fascia lata placed in the defect of the posterior wall of the inguinal canal. This is accomplished without tension and is sutured with interrupted sutures that are tied snugly but do not produce tension or strangulation of the tissues. By using this method, the defect in the wall of the inguinal canal is "patched" by living fascia and muscle with its nerve and blood supply intact.

The conventional exposure of the hernial sac is carried out, and the sartorius muscle exposed through a long thigh incision. Then the sartorius muscle and fascia lata are divided by transverse incision in the middle third of the muscle. The fascia lata is then incised both laterally and medially to the sartorius muscle; the muscle is freed from its bed and drawn upward, leaving its blood and nerve supply intact. The muscle and fascia flap are now transferred into the defect in the posterior wall of the inguinal canal, exercising care not to injure the blood and nerve supply or to disturb the origin of the muscle at the anterior superior iliac spine. The fascia lata is first sutured to the rectus sheath, conjoined tendon, internal oblique and Poupart's ligament with interrupted sutures. The sartorius muscle is then sutured to the same structures anterior to the fascia graft with interrupted sutures. All sutures are tied without tension.

TRENDS IN POSTOPERATIVE CARE

Less than ten years ago, in our zeal to prevent recurrence, we maintained a policy at the New York Hospital of complete immobilization of hernia patients during the first week following operation. This immobilization included not turning in bed and being kept as quiet as possible, often supplementing instructions with sedatives. All patients were kept in bed for a period of fourteen days. At the end of that time, the patient's activity was limited for several days until he could regain his strength suf-

ficiently to get about. Since 1945, however, we have changed our policy to one of early mobilization. The patient stands to void on the day of operation, walks about on the day following operation, and thereafter continues his activity.

Dietrich[19] and his co-workers have demonstrated in their metabolic studies on patients mobilized and immobilized that a favorable nitrogen balance is maintained in the patient who is allowed to move about. This prevents the development of invalidism and furthermore, tends to maintain the proper nutritional balance in the body, which is, of course, reflected in tissue healing. It has been our experience thus far that the incidence of recurrence has been diminished rather than increased by this practice and we therefore now consider it an established postoperative routine to mobilize patients as soon as practicable after operation.

The use of antibiotics in patients with a complicated hernia associated with infection needs no elaboration here, but we have not found necessary, nor do we advocate the prophylactic use of penicillin or other antibiotics following operation. Proper management of fluids and nutritional needs are reduced to a minimum by early mobilization and we believe that postoperative care directed at early mobilization will further reduce all postoperative complications. Our experience with 1,385 consecutive cases shows this to be true. A careful analysis of our last series reveals 95 patients that developed postoperative complications of varying significance, six of which ended in death, a mortality rate of 0.4 per cent. Three of these six deaths, however, were due to peritonitis associated with acute hernia, and were, in fact, examples of patients upon whom the treatment for hernia had been too long postponed.

The problem as to when an individual may resume his normal occupation following a hernia operation depends on several factors: the age of the patient, the type of hernia, the method of repair used, and the nature of his occupation. The compensation courts, for the most part, consider that an individual should be allowed eight weeks to recuperate from his operation before returning to work. For the person doing manual labor this is probably the safest policy to follow. However, if healing is complete at the end of two weeks, and the patient has been up and about, he can probably return to work much sooner. This is particularly true of an office worker or any individual who is not likely to be subjected to unusual muscular effort.

TRENDS IN RESULTS

We now come to our observations on the trend in results from the surgical treatment of hernia. McVay[8] has recently reported a series of 100 hernial repairs without a known recurrence in a follow-up of five to eight years for his first group of 35, and 10 to 28 months for the second group of 65 cases. Of the 100, 56 are classified as difficult repairs, including twelve recurrent cases.

In our experience at the New York Hospital we have found that our results have improved over the years. In 1936[20] we reported 500 hernial operations, as follows:

RESULTS IN 500 HERNIA OPERATIONS
The New York Hospital 1932-1935

Type of Hernia	Number of Operations	Number Followed	Number of Recurrences	Per Cent of Recurrences
Indirect inguinal	303	253	6	2.4
Direct inguinal	38	32	2	6.3
Recurrent inguinal	26	20	6	30.0
Femoral	33	26	3	11.5
Umbilical	34	28	–	–
Epigastric	18	14	2	14.3
Postop. ventral	48	41	–	–
	500	414	19	

These results, as far as the recurrence rate goes, appear better than those reported in our later series[3] of 1,545 hernia operations done between 1940 and 1944:

RESULTS IN 1545 HERNIA OPERATIONS
The New York Hospital 1940-1944

Type of Hernia	Number of Patients	Number of Operations	Follow-Up Results: Number of Patients Followed	Number of Repairs Examined	Number of Recurrences	Per Cent of Recurrence
Indirect inguinal	770	840	559	616	19	3.1
Direct inguinal	205	279	144	220	18	8.2
Recurrent inguinal	95	103	86	95	14	14.7
Femoral	110	114	94	94	8	8.5
Umbilical	57	57	43	43	5	11.6
Epigastric	12	12	11	11	1	9.0
Postop. ventral	136	140	100	100	12	12.0
	1,385	1,545	1,037	1,179	77	

This larger group, however, contains more difficult problems in hernial repair and represents an older age group which was followed for a longer period of time than the earlier group. The later group also includes many patients that would not have been considered suitable for operation in the earlier period.

These figures parallel reports from many other clinics in that they suggest that every attempt should be made to do whatever operative repair is indicated for inguinal hernia at the time of the primary operation. Each patient should be carefully evaluated and no single procedure should be expected to apply to all patients. Individuals with weak structures should be subjected to the type of repair that will give

them the greatest insurance against recurrence. For example, a patient with an indirect inguinal hernia who has a poor transversalis fascia and possibly a weakened Poupart's ligament should have a McVay type of hernioplasty or a Halsted repair with transplantation of the cord to the subcutaneous tissue, rather than removal of the hernial sac and restoration of normal anatomical relationship of structures in the inguinal region. If the latter is done, such a patient is likely to develop a direct hernia type of recurrence at the site of his weakest structure in the inguinal region.

Our results may be further improved by operating on all hernias as soon as they are diagnosed, advocating in so doing that a truss not be worn for mere convenience. The patient who is advised to wear a truss as a matter of convenience or as a temporary measure, too often accepts this advice as being the proper treatment for his particular case. Such a practice only leads to the necessity for a more difficult procedure when the repair is made later on, and is also accompanied by the hazard of complications such as incarceration, strangulation, and intestinal obstruction.

These principles should also be followed in the treatment of postoperative ventral hernia. When a hernial defect is demonstrated in the abdominal wall wound, that defect should be repaired as soon as the induration and reaction from wound healing has subsided. A hazard to the patient exists if any defect is permitted to remain, and of course the smaller defect is much easier to repair than the larger one. The risk to the patient from his operative burden is also much less if it is not necessary to return a large portion of the viscera to the abdominal cavity.

Acute hernia as a problem will continue to account for a large proportion of the mortality associated with hernia repair, but the mortality rate can be reduced if the best possible surgical judgment is used. Acute hernia in a late stage of intestinal obstruction often exhibits a picture of profound shock and must be handled as carefully as shock from any other cause. With our better understanding of fluid and electrolite balance, the various methods of decompressing the intestinal tract, and chemotherapy, many of these patients can be salvaged. There is perhaps no other group of patients in surgery with whom we should proceed more cautiously, and we should keep in mind that to do too much too quickly may prove fatal.

CONCLUSION

The surgical repair of hernia as done in most general hospitals throughout the country, is a frequently performed and highly successful procedure. Each succeeding decade sees further improvement in the end results of these operations. Improved surgical technique is but one of the several factors accounting for this favorable trend. Other factors include earlier diagnosis and operation, better preoperative preparation, more selective anesthesia, adaptation of the type of repair to correct more perfectly the structural defect, employment of finer suture material, better postoperative management including early postoperative mobilization, and chemotherapy in those instances of "acute" hernia complicated by infection.

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Allergy in General Practice

One of the few advances in clinical allergy has been the realization that many cases of intractable asthma and vasomotor rhinitis beginning after the age of 40 are not due to the usual environmental allergens. Bacterial allergy, "depletion," psychosomatic factors, emphysema, tumors, and foreign bodies are the more important etiologic factors in these patients.—Milton S. Clark, M. D., Goldsboro; North Carolina Medical Journal, Vol. 10, No. 11, November, 1949.

Medical Follow-up of Vagotomy Plus Gastro-Enterostomy Or Pyloroplasty For Peptic Ulcer*

E. N. COLLINS, M. D., GEORGE CRILE, Jr., M. D., and W. S. DEMPSEY, M. D.

DURING the past three years and three months 360 patients have been subjected to bilateral vagotomy for complicated peptic ulcer at Cleveland Clinic Hospital. Two annual reports of our experience have been published.[1, 2] The transabdominal approach plus gastro-enterostomy or pyloroplasty was adopted as the procedure of choice.

The present report concerns the first 100 consecutive patients having this combined procedure for complicated duodenal ulcer.

Bilateral vagotomy plus gastro-enterostomy ---------- 73 patients
Bilateral vagotomy plus pyloroplasty---------- 27 patients
(Operations performed by Drs. T. E. Jones and George Crile, Jr.)

Gastric ulcer is not included in this report because we believe gastric resection is the surgical treatment of choice for this disorder. Neither are jejunal or marginal ulcers considered, even though we have found, and it is generally accepted, that bilateral vagotomy is an effective method of treatment.

Members of our group are conservative in advising surgical procedures for duodenal ulcer. At least 85 per cent of our patients make satisfactory progress on medical management. Therefore, the only patients operated on had complicated problems. In most instances the patients were incapacitated and unable to follow their usual occupations.

Complications prior to operation:

Pyloric obstruction	24
Massive hemorrhage	21
multiple	9
Acute perforations	10
multiple	2

Twenty of the 24 patients having pyloric obstruction had 50 to 100 per cent gastric retention in six hours by roentgen examination. More than half of the patients in this series had intractable pain, including night pain, and medical management was not effective.

The sex and age distribution and the duration of symptoms are as follow:

100 consecutive patients having complicated duodenal ulcer.

Sex	85 men		15 women
Age	Average		47 years

Duration of ulcer symptoms—average 12.6 years

RESULTS OF FOLLOW-UP STUDIES

Results to date are known in 97 of the 100 consecutive patients. One patient died while in the hospital and one patient died six months after operation of an unrelated disease. We were unable to trace two patients. Another patient had obtained an excellent result at the end of nine months but we have not seen him recently.

This follow-up study, therefore, concerns 95 patients who have been followed twelve to twenty-nine months. The average duration of follow-up studies has been twenty months.

Insulin tolerance tests and drainage studies, unless positive, have not proved reliable in determining the completeness of the vagotomy in this investigation, because of regurgitation of duodenal contents. Therefore, this appraisal is based on a survey of clinical results.

QUESTIONNAIRE

A questionnaire was filled out by the patient at the time of progress examinations or has been received by mail within the past month.

The Authors

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*From the Cleveland Clinic and the Frank E. Bunts Educational Institute.
Presented before the Section on Medicine at the Annual Meeting of the Ohio State Medical Association, Columbus, April 21, 1949.

1. Have you had any recurrence of your ulcer-like pain?

(Pain in the upper abdomen occurring two or three hours after meals and relieved by food.)

Yes ..... 3 patients
No ..... 92 patients

One of the three patients who answered "yes" developed a jejunal ulcer nine months after operation, demonstrated by roentgen examination. At the second operation, in addition to the jejunal ulcer, three additional intact vagus fibers were found. He has had two subsequent operations and prior to each operation he had had highly positive insulin tolerance tests. It is now known that complete vagotomy is not possible in approximately 5 per cent of patients, due to anatomical variations in the distribution of the vagus nerves.

The other two patients who answered "yes" have had progress roentgen examinations. There was no evidence of an ulcer crater, the stoma functioned normally, and motility studies were normal.

2. Have you had any abdominal pain of any type? If so, describe:

Yes ..... 33 patients
No ..... 62 patients

Three of the 33 patients who answered "yes" were those who answered "yes" in question one, four have a mild "dump syndrome," and the remainder have gaseous dyspepsia characteristic of an irritable colon syndrome or incisional pain.

3. Have you vomited? If so, how often?

Yes ..... 15 patients

2 repeated, 3 transitory, 10 mild (1 to 6 times a year)

No ..... 80 patients

One of the 15 patients who answered "yes" was the one who developed a jejunal ulcer. The other patient who has had repeated vomiting has been classified as a failure, despite negative roentgen findings.

Progress roentgen examinations in the remainder of the group answering "yes" to this question have revealed normal findings, including normal motility.

4. Have you had diarrhea? If so, how many stools per twenty-four hours?

Yes ..... 35 patients
transitory 7
occasional 20
mild 6
severe 2
No ..... 60 patients

The patients in the "transitory" and "occasional" groups were not concerned about their diarrhea. Those having recurrent mild diarrhea have less than four stools daily while the patients classified as having recurrent severe diarrhea have four to six stools daily. In no case has the diarrhea been disabling. Food allergy seemed to be an important factor in a number of these patients.

5. How much weight have you gained?

58 patients—average gain 20 pounds
16 patients—no change
8 patients—lost weight—average 15.2 pounds
13 patients—did not state

We were surprised to find that eight patients stated that they had lost weight. On going over the charts of these patients, we found that three had been using a weight reducing diet and that in three other instances by comparing their weight after operation with their present weights, they actually had not lost over six pounds.

In an attempt to appraise the result in 95 patients having follow-up studies over an average period of twenty months, the following criteria were used:

Excellent	One hundred per cent normal health from gastro-intestinal standpoint.
Satisfactory	No ulcer distress; gastro-intestinal symptoms so mild that they do not interfere with work; no special diet or medication used.
Improved	No ulcer distress; fewer gastro-intestinal symptoms than before operation, but diet and/or medication have been used to control symptoms.
Failure	Persistence of ulcer-like distress or development of other gastro-intestinal symptoms sufficiently severe to constitute disability.

A summary of the results is as follows:

	Excellent	Satisfactory	Improved	Failure
Cases	62	20	10	3

Excellent plus satisfactory—86 per cent.

Three of the 95 patients were considered to be in the failure group. Details concerning the patient who developed the jejunal ulcer, who had an incomplete vagotomy, have already been mentioned. The other two patients have had progress roentgen examinations. There was no evidence of an ulcer crater, the stomach functioned normally, and motility studies were normal.

One patient is a retired physician, who is now residing in Florida. He has symptoms referable to many parts of the body particularly the cardio-vascular system, including intermittent ulcer-like symptoms.

The other patient is a 28-year-old registered nurse, who states that she had epigastric burning at times, as well as intermittent diarrhea not to exceed four stools in any twenty-four hour period. As stated, the roentgen examination demonstrated an excellent result from the operation, but she has used antacids at times and is therefore considered a failure.

The patients who are placed in the excellent and satisfactory groups are following no special diet, taking no medicine, and have no significant symptoms. It will be noted that 92 patients included in the first three categories are free of ulcer distress and are in much better health than before operation. Only three of the 95 patients are classified as failures.

COMMENTS

It is difficult to appraise the results of treatment in any disease characterized by spontaneous remissions. An experience of many years is necessary for the final evaluation of any form of treatment of peptic ulcer. Members of our group are conservative in advising surgical procedures, because at least 85 per cent of our patients having duodenal ulcer make satisfactory progress on medical management.

The present report concerns the first 100 consecutive patients having bilateral vagotomy combined with gastro-enterostomy or pyloroplasty for complicated duodenal ulcer.

We were able to follow 95 patients over an average period of twenty months.

Renshaw and Beck[3] reviewed twenty-five years' experience of our staff with conventional surgery, i. e., gastric resection or gastroenterostomy alone. The greatest percentage of recurrence occurred within the first year after operation.

The patients in the group reported here have obtained better results than comparable series of patients having conventional surgery, followed over a similar period of time.

The mortality rate was 1 per cent.

One patient developed a jejunal ulcer with obstruction. It apparently was impossible to do a total vagotomy in this instance. Otherwise, no patient in this series has developed roentgen evidence of recurrent ulcer, and no patient has had a recurrence of obstruction, hemorrhage, or perforation.

At the present time when elective surgery is indicated for complicated duodenal ulcer, our group favors bilateral vagotomy plus gastroenterostomy or pyloroplasty.

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KEEPING UP WITH MEDICINE

• IN Philadelphia a survey of 18 patients who were the recipients of the blood of a single donor over a period of three and a half years, showed four of the 12 who survived for a reasonable length of time developed hepatitis with icterus. It is suggested that the donor was a carrier of the virus.

* * *

• THE occurrence after the administration of sulfathiazole of a rash similar to erythema nodosum has been reported frequently. But the drug is looked upon by most workers as a provocative and not an etiologic factor.

* * *

• TETRAETHYLAMMONIUM chloride injected intravenously has an antipuritic effect similar to that of other vasodilators.

* * *

• TODAY the importance of allergic factors in precipitating attacks of gout is being stressed.

* * *

• LANGE and his associates insist that glomerulonephritis is caused by a continuous organ specific antigen-antibody reaction.

* * *

• IF we omit the "CORPUS HIPPOCRATICUM," the writings of Galen represent at least five-sixths of all of the medical writings surviving from antiquity.

* * *

• FROM twenty to forty years of age is the time in which neglected Eustachian tube deafness becomes the conduction disability of maturity and the inadequately treated secretory ears become the adhesive deafness of adulthood.

* * *

• THE day when the surgeon's responsibility was limited to the local injury, and ceased when that is healed has passed. The patient must be rehabilitated.

* * *

• WHEN there is a cough—non-productive, dry, hacking in character, a streaking of blood at times, not explained to your complete satisfaction, take an X-ray plate of the chest looking for a carcinoma. Here we search for: (1) Localized emphysema secondary to bronchial obstruction; (2) or the subsequent atelectasis; or (3) increased density of the hilum with growth in the wall of a similar bronchus; or (4) a growth in the periphery of the lung, producing slight discomfort referable to the pleura.

* * *

• REITER'S syndrome presents the triad of urethritis, conjuctivitis, and polyarthritis.

* * *

• JARRING of vehicles with few, poor, or no springs for the protection of riders, is an infrequent but important cause of intervertebral disk syndrome in truck drivers.—J. F.

The Treatment of Sterility: Report of 100 Consecutive Cases

MOSES GARBER, M. D.

STERILITY is a major social problem in the United States since approximately 10 per cent of all marriages are barren. This is exclusive of the childless matings which result from habitual abortions. The subject of sterility, therefore, occupies considerable time and attention of the gynecologist who undertakes the relief of this distressing condition.

The prerequisite to successful treatment of sterility is a painstaking and thorough search for the cause in both husband and wife, since the responsibility for the sterile mating is almost equally divided. In the present series of 100 consecutive cases treated, the ratio was 35 male to 65 female (Table I). TeLinde states

TABLE I

Male	27
Female	73
Total	100
Female—	
Youngest	18 yrs.
Oldest	45 yrs.
Average Age	29
Average Number of Years Married	5.5
Male and Female Defects	8
Male Defects	27
Aspermia	6
Defective Sperm	21

that in his experience the ratio was nearer to 50 per cent male to 50 per cent female.

In the course of the investigation and treatment it becomes often necessary to consult other specialists; such as the internist, endocrinologist, urologist and roentgenologist.

It is a known fact that spermatogenesis is depressed by constitutional diseases and faulty nutrition, especially protein deficiencies; also by acute and chronic diseases and intoxications. The treatment of these depressed nutritional states and diseases is best handled by the internist. Similarly, spermatogenesis is affected by thyroid and pituitary dysfunctions and the endocrinologist is called upon to correct these abnormalities; the urologist treats the infective and obstructive lesions in the sterile male, especially those of the prostate, since the prostatic secretions constitute a considerable and important part of the seminal fluid.

The collaboration of the various specialties for the relief of sterility applies also to the female except for endocrinology which has become by usage, the field of the gynecologist.

Read before Mt. Sinai Hospital Medical Society, January 13, 1949.

The Author

● **Dr. Garber, Cleveland, Ohio, is a graduate of Western Reserve University School of Medicine, 1910; fellow, American College of Surgeons; consultant, in obstetrics and gynecology, Mt. Sinai Hospital.**

In the cases to be reported, the following procedures were carried out before treatment was begun:

1. Examination of semen as to quantity, viscosity, morphology and endurance. If the semen was found deficient, the husband was referred to an urologist for study and treatment.

The wife underwent the following examinations:

a. Detailed general, menstrual and marital history.

b. Physical and pelvic examination with especial regard to vaginal and cervical secretions and pelvic tumors, infections and displacements. Gas insufflation for patency of the fallopian tubes was done. Examinations of urine, blood, serology, and basal metabolic rate were also done. Special endocrine problems involving the pituitary, thyroid and ovary were investigated prior to treatment and as far as possible, the gland causing the dysfunction was determined.

These examinations have shown clearly that in many cases, there is more than one factor concerned in sterility, and the treatment was varied accordingly.

For the successful treatment of sterility, attention should be paid to minor as well as major factors. This involves educational, local, constitutional, endocrine, roentgenological and surgical treatment.

EDUCATIONAL

The proper placement of the seminal fluid in the vagina is quite important especially in men of low fertility. In cases of uterine displacement, the external os may be out of reach of the meatus; for proper insemination, modification of posture during intercourse is advisable.

Sexual excesses or intercourse at long intervals are both conducive to infertility.

Intercourse should be timed to coincide with ovulation and a period of several days continence before ovulation time may be helpful.

Unnecessary frequent douching, especially with certain fragrant douching powders are to be interdicted. If the acidity of the vagina is high, a douche of one tablespoon of soda bicarb to two quarts of water one-half hour before coitus may be used. Getting out of bed to urinate immediately following intercourse may result in the loss of a major part or all of the seminal fluid.

Removal of phallus from vagina immediately after ejaculation may result in considerable loss of seminal fluid, especially in women with a short vagina and shallow perineum.

LOCAL

Hostile vaginal and cervical secretions may destroy the viability of the sperm before they get a chance to enter the cervix. A douche of Ringers' solution with 2 per cent glucose before coitus during the fertile period may be used to overcome this condition. Cervical plug of thick inspisated mucus or muco-pus presents an insurmountable barrier to the ascent of the sperm. This is to be treated with the cautery. Caution should be exercised in this procedure not to destroy the cervical glands completely or produce stenosis of cervix. Endocervicitis should be treated although as a rule, it is not as frequent a cause of sterility as is the cervical plug.

The constitutional treatment in healthy women deals mainly with their state of nutrition, obesity and anemias, if present. A high protein diet is prescribed for all women. Obesity is rather common among sterile women and weight reduction is undertaken in conjunction with small doses of thyroid extract when the basal metabolic rate is within normal limits. Larger doses of thyroid are given to women with a low metabolism. Similarly moderate anemias are treated with iron. Vitamins E and A are prescribed on general principles in the hope that there may be a Vitamin E or A deficiency causing hypo-ovarianism.

THE ENDOCRINE TREATMENT

A certain number of sterile women present definite dysfunctions of the pituitary or ovarian glands. The diagnosis is not always clear but can be made in a goodly number of cases from a detailed history, physical and pelvic examination. The problems in these cases center mostly around the menstrual function and uterine hypoplasia: amenorrhea, oligomenorrhea, irregular menses and small or infantile uterus. These are treated by various combinations of estrogens, progesterone and chorionic gonadotropins. There are no hard and fast rules to follow in this treatment but generally speaking patience and sufficient treatment succeed in a considerable number of cases. In cases of pituitary deficiency, X-ray exposure may regulate the menstrual function and relieve sterility. Two cases of successful pregnancies followed this treatment (Table 2).

TABLE II

Female Sterility 73	
1. Complete or Partial Tubal Obstruction	19-25%
2. Uterine Hypoplasia	17-23%
3. Infected Cervix (Cervical Canal Plugged)	9-12%
4. Ovarian Failure	4-4½%
5. Pituitary Obesity	4-4½%
6. Hypothyroidism	5-6%
7. Cystic Ovaries	3
8. Fibroid	3
9. Endometriosis	2
10. No Ovulation	2
11. Anxiety Neurosis	1
12. Refusal to Inseminate Wife	1
13. Acute Anteflexion	1
14. Malignant Hypertension after Therapeutic Abortion	1
15. Tight Vagina (Dyspareunia)	1
	73

SURGICAL TREATMENT

Surgical treatment includes the following:

Repeated tubal insufflation and biopsies, dilation and currettage, stem pessary, removal of pelvic adhesions, and plastic operations on the tubes. In cases of partial tubal block, repeated gentle insufflation may straighten out a tube distorted by adhesions. In such cases two insufflations a month, several days apart are done during the fertile period. In case of pregnancy following repeated tubal insufflations for partially obstructed tubes, ectopic pregnancy may occur (Table 3). A dilatation and currettage may correct endometrial hyperplasia, regulate menses and occasionally result in pregnancy.

TABLE III

Therapy	
Diet and Thyroid	6
Diet and Thyroid+Endocrines	42
Plastic Operations on Tubes	6
Myomectomy (Followed by Pregnancy)	1
Artificial Insemination	9
X-ray Therapy to Pituitary	2

In an acutely flexed uterus causing dysmenorrhea, insertion of a stem pessary may give relief occasionally but it is questionable whether this procedure is of benefit in relieving sterility. On the other hand, the correction of uterine displacements either by pessary or suspension of uterus are useful in the treatment of sterility. In complete tubal occlusion an attempt may be made to reestablish the patency of the oviduct by a plastic operation on the tube. In this series four pregnancies followed plastic tubal operation and one after myomectomy.

Three of these pregnancies resulted in full term pregnancies. Endometriosis is usually accompanied by sterility. A pelvic operation for endometriosis of an ovary or tube may relieve the sterility. Artificial insemination of the wife with her husbands' sperm in case of cervical obstruction or hostility may often prove successful. In this series there was one successful pregnancy in four women, thus inseminated. In cases of aspermia the wife may be inseminated with the sperm of a donor other than her husband. It is successful in about 1/3 of the cases, depending largely upon the fertility of the donor.

Table I shows the ratio of male and female sterility as 27 male to 73 female. However, there were 8 cases in which there were male and female defects, making the ratio 35 male to 65 female. The average number of years married was 5.5, which indicates that a mating is not treated for sterility until several years of married life elapsed (usually three years) without the use of contraception. The youngest patient in this series was 18 years old and her sterility was due to complete tubal occlusion.

Table II deals with the causes of female sterility and it indicates that the most common causes were tubal block (19 per cent), uterine hypoplasia (17 per cent), and cervical plug due to infection (9 per cent) while pituitary, ovarian and thyroid dysfunction accounted for 13 cases about equally distributed.

Table III deals with the treatment. It will be noted that 42 of the 73 women were treated by diet, thyroid and endocrine preparations. Nine were artificially inseminated and seven underwent plastic operations on tubes and uterus, while two had X-ray treatments of pituitary gland. There were no cases of X-ray treatment to ovaries.

Table IV deals with the results obtained in the various treatments of this series: 31 women became pregnant resulting in 41 pregnancies.

TABLE IV

Results	
Number of Women Who Became Pregnant	31
Total Number of Pregnancies	41
Number of Viable Babies	33
Number of Miscarriages (1 Woman Had 3)	6
Number of Ectopic (Tubal) Pregnancies (One Woman Had 2 Unruptured Ectopies) (Previously One Ectopic)	2
Viable Babies after Plastic Operation (One Following Myemectomy)	3
Viable Babies after X-ray Treatment	2

Number of viable babies was 33, miscarriages six, ectopics two; three viable babies following plastic operations and two viable babies after X-ray treatment.

Table V shows that in six women with aspermic husbands, four women became pregnant after insemination and gave birth to six babies, five of whom were viable and normal; while one terminated at six months' delivery due to premature separation of placenta.

TABLE V

Aspermia—Artificial Insemination	
Number of Women Inseminated by Donor	6
Number of Women Who Became Pregnant	4
Number of Viable Babies	5
Number of Nonviable Babies (6 Months Premature Separation of Placenta)	1
Total Number of Pregnancies from Artificial Insemination (Donors)	6
Women Inseminated from Husband	3
Viable Babies from Insemination (Husband)	1

There were also three women inseminated from their husbands with one viable baby.

SUMMARY

One hundred consecutive cases of sterility were reported with 41 pregnancies in 31 women, with 33 viable babies, six miscarriages and two ectopic pregnancies.

Many medical and surgical forms of treatment and procedures were carried out since more than one cause was found in most of these cases of sterility. Attention to minor as well as major factors as probable causes of infertility was necessary to obtain good results.

The Sore Mucus-forming Colon

One of the commonest complaints of nervous, tense women is soreness, mainly in the lower abdomen. It is associated perhaps with constipation and usually with the frequent passage of mucus and gas. I think it is most unfair to show these women their roentgenograms and to tell them they have a spastic colon. Every such woman has a colon which tends to contract down hard on the left-hand side, and what one should emphasize is the fact that it is a perfectly normal colon; what is wrong is only that the nerves are playing tricks with it. Where I work the roentgenologists never, from one year's end to another, make a diagnosis of a spastic colon; they know that practically all colons are spastic, so why mention it? As I said, the big point to make to these persons is that the colon is perfectly normal, and it is not particularly subject to any disease such as cancer. The patient never will come to any bad end because of the mucus colics. Another very important point is not to call this trouble "colitis." It is not colitis because the colon is normal. The term "colitis" should be kept for diseases in which the colon is inflamed or ulcerated.—Walter C. Alvarez, Rochester, Minn.; Rhode Island Medical Journal, Vol. XXXII, No. 11, November, 1949.

Electro-Mechanical Aids In Resuscitation and Anesthesia*

MR. KENNETH WOLFE and MR. H. J. RAND, III

WE are presenting (1) a new mechanical respirator operated by electric power; (2) vacuum cup electrodes for more effective massage of the failing heart; (3) an electric shock apparatus for shocking the fibrillating heart into standstill from which condition it can resume a normal rhythm.

MECHANICAL RESPIRATOR

Many devices have been used to provide artificial respiration but there are few machines which effectively serve the dual purpose of anesthesia and resuscitation. Two of the latter type in present day use are the respirators designed and used by Dr. Clarence Crafoord, Stockholm, Sweden, and by Dr. Frederick R. Mautz, Cleveland, Ohio. These machines compress the rebreathing bag by means of air pressure and the latter machine requires a source of compressed air for operation. The first machine has an electrically driven air compressor but is not adapted for use with standard anesthesia gas apparatus. We developed this particular design embodying an electric power unit and mechanical compression because we recognized the need for a respirator which can be used anywhere that a gas machine can be used. Alternating current is always present and modern engineering practice has made its use as safe as the use of compressed air.

The respirator is equipped with a General Electric one-sixth horsepower explosion-proof alternating current motor, an explosion-proof "Off-On" switch, and a standard plug. The machine must be grounded in accordance with provisions of the local electrical code. The motor pulley drives by means of a belt a gear reduction unit, the output shaft of which rotates a can which in turn moves an aluminium disc up and down compressing the rebreathing bag against a stationary upper disc. The upper disc can be raised or lowered by means of the "Pressure Control" knob in order to adjust the pressure when the oxygen flow into the system is maintained at a constant value. The bag is fastened to the two discs by rubber cuffs cemented to the bag and a slight suction is developed during the expiratory phase of respiration. The cam is so designed as to produce a respiratory cycle similar to that of normal deep breathing. There is a gradual increase in pressure to a peak, a pause consisting of 25 per cent of the cycle, and then a sudden release of pressure. This is the mechanism produced by the anesthetist as she compresses and releases the rebreathing bag. The mechanical respirator repeats this cycle at a selected rate, 14 to 28 respirations per minute, as long as needed. The speed is varied by turning the "Speed Control" knob which loosens or tightens the driving belt, thus changing its position in the groove of the expansion pulley and giving the machine a two to one speed range. The surgeon, performing delicate surgery on the heart or elsewhere in the chest, can adapt his reflexes to the rhythm of the machine.

The transition from routine anesthesia by the closed system with a tracheal tube in place is easily accomplished.

1. Start the motor and adjust the rate.

2. Remove the rebreathing bag from the gas machine and make an airtight connection between the carbon dioxide absorber and the respirator outlet by means of a short rubber tube.

3. Fill the bag system with oxygen and anesthetic mixture. Adjust the flowmeter so as to maintain a pressure of 10 millimeters of mercury in the bag as recorded on the pressure gauge.

4. During the operation, small changes in pressure can be compensated for by adjustment of the "Pressure Control" knob but large changes must be taken care of by means of the gas machine controls. With an air-tight closed system, there will be very little variation in pressure except when additional lobes of lung are collapsed to provide exposure.

MAINTENANCE

Occasional lubrication of the motor pulley is required. The rebreathing bag can be easily removed for cleaning. We recommend the use of water only as many solvents will dissolve the cement binding the bag and cuffs.

VACUUM CUP ELECTRODES AND ELECTRIC SHOCK APPARATUS

The second apparatus has two functions: First, the vacuum cup electrodes aid in providing an effective heart beat by massage; secondly, the controlled shock brings all the muscle fibers of the fibrillating heart into complete standstill from which condition it can resume a normal rhythm.

Before the heart can be defibrillated successfully, it must be massaged until much of the dilatation is eliminated, until a good tone re-

*Part III of a symposium on "Acute Cardiorespiratory Failure: Requirements for Successful Resuscitation", presented at Annual Meeting of the Ohio State Medical Association, Columbus, April 20, 1949.

places the flabbiness of the ventricular wall, and until the color becomes pink showing that oxygenated blood is circulating through the heart. Hand massage alone is frequently inadequate and does not bring about these conditions.

The apparatus operates on 110 volts alternating current. The vacuum cup electrodes are placed on opposite sides of the fibrillating ventricles. Each vacuum cup has its own vacuum pump and associated controls so that the suction can be adjusted to the exact amount necessary to hold it firmly against the ventricular wall. The power switch actuates the motor driven pumps and pilot light; the control valves adjust the amount of vacuum produced as indicated on the gauges. Approximately 5 inches vacuum has proven satisfactory on the dog heart and this adjustment is made with the cups in contact with the ventricular wall. The heart is now massaged vigorously at a slower than normal rate so that it can fill and empty as in life. In a few seconds it will become pink with oxygenated blood.

When we are ready to shock the heart, we turn on the power switch which also actuates a buzzer and a pilot light to inform the surgeon that the apparatus is ready for use. The auto-transformer and the variable resistor are adjusted to give approximately one ampere through the heart. The alternating current voltage is indicated on the voltmeter and the current on the ammeter. The surgeon can administer the shock by means of the switch on the handle or his assistant can use a switch on the panel itself. This switch also energizes the pilot light.

If the first shock is unsuccessful, further massage is carried out, procaine is used on the surface and in the ventricles, and a second shock is given at a slightly higher current. If additional shocks are necessary, the current is increased gradually for each shock until the maximum is reached. This increase is obtained by turning the auto-transformer knob to the right until the maximum voltage is reached and then turning the variable resistor handle to the right to reduce the resistance. When the normal heart beat returns, it is aided by gentle massage and stimulated by the injection of adrenalin. Artificial respiration, by means of the mechanical respirator, is continued until normal respiration returns.

CONCLUSION

In this apparatus, we have combined proven principles of resuscitation in such a manner that the surgeon has readily available the essentials to revive a failing heart. We have introduced a new concept in the use of vacuum cups as an aid in effective massage of the heart. We have developed a mechanical respirator which should prove of value in both anesthesia and resuscitation.

Mass Radiography

I have recorded elsewhere the serious limitations, erroneous interpretations, and liabilities of mass radiography and the relative poverty of its contributions to preventive medicine. Undoubtedly it has an important propaganda value, but it is the propaganda of fear by which the public—yes, and the medical students—are being frightened into the erroneous belief that active progressive disease is symptomless and only the radiology can reveal it. It can be proved to have been responsible for the infliction of much unnecessary mental and physical pain.

Mass surveys are essentially bureaucratic regimentation measures designed by officials and enthusiasts who appear not to have the knowledge of the five omissions or the experience to judge the efficiency of the measures adopted, and, while they themselves are spared the rigours and anxieties of the general practitioners attending to the sick, would decry the contributions of these latter doctors to the reduction of the incidence and mortality from tuberculosis. Mass radiography has not added anything new to our knowledge of radiology of the chest. The evidence obtained by it has been used to re-emphasize the fact that 4 per 1,000 of the population have signs of active tuberculosis; but not enough importance has been placed on the other confirmatory evidence it has yielded—i.e., that at least ten times as many persons, or 40 per 1,000, have had fairly extensive disease and recovered from it without knowing of its existence and in most cases without having lost time from work. Had radiography been applied to all these at the stage when the appearances suggested activity it would have inflicted on them the dreaded stigma of tuberculosis and seriously interfered with their lives without contributing any good. A little reasonable education in hygiene would have accomplished much more, at less expense in money, equipment, buildings, personnel, and above all in feelings.

Because there would appear to be conditions of medical service which permit certain cases of pulmonary tuberculosis to be overlooked by medical officers is an indication not that the progressive disease is symptomless but that the clinical examinations are poor; for when such patients return home the diagnosis is made by the parents, confirmed as grave by the general practitioner, and registered as deadly by the consultant a few days before death. The greater the percentage of cases of unknown progressive tuberculosis discovered by mass radiography, the poorer the clinical medicine that has been applied.—James F. Brailsford, M.D., British Medical Journal, No. 4630, October 1, 1949.

Sight Restoration Program of the Cleveland Society For the Blind

CHARLES I. THOMAS, M.D.

IN 1944, a member of the Board of Trustees of the Cleveland Society for the Blind had the thought that there might be a considerable number of people who came under the care of the Society who possibly might be helped by medical and surgical aid. This individual discussed the proposition with Dr. W. E. Bruner, and it was decided to investigate the records and evaluate the medical status of each person who was enrolled in the program of this organization.

Dr. Bruner asked me to collaborate with him in this work and the entire program was conducted under his supervision. Our procedure was as follows.

In order to determine the number of people who might be helped by treatment, either surgical or medical, the record of each individual was carefully examined and those that presented a favorable diagnosis, or one that suggested the possibility of sight restoration, was withdrawn and classified for further examination and study. It did not take long to realize that a considerable number of people would fall into the group for the sight restoration program, and the Society would be faced with a heavy financial burden to pay for the hospital care that was necessary to carry this out.

Funds for this program could not be allocated from other departments so it was assumed that the program must have a separate endowment and these funds must be obtained from outside interests.

As the Cleveland Society for the Blind is a community-supported organization, it attempts to keep the people of Cleveland informed of its activities. In order to raise additional funds for the sight restoration program, certain people in Cleveland were approached to whom the program was outlined and explained, and contributions were asked. The response was favorable and during the first year $10,000 was raised by donation. This, of course, was only to be used for sight restoration procedures such as surgical and medical hospital care, nursing service, medication and eye glasses.

With such a program, a certain amount of publicity is inevitable, but we feel that this has always been on an ethical basis and we must certainly admit that it has been essential in obtaining the necessary financial aid that makes the program function.

Presented before the Section on Eye, Ear, Nose and Throat at the Annual Meeting of the Ohio State Medical Association, Columbus, April 19, 1949.

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In order to show what a program of this type costs, the following figures are from the financial statement of the organization: The donations to date have amounted to a total of $19,704.17. This is inclusive from February, 1944, to December, 1948. Of this amount, $16,748.70 has been spent to date. Itemizing the expenditures, we find the following:

1.	Hospital	$8,816.47
2.	Nursing	5,510.50
3.	Research, including laboratory equipment and technician	1,000.00
4.	Eye glasses	1,071.80
5.	Medicines	50.93
6.	Photographs	30.00

These figures show that there is a relatively small balance for further work, but we feel confident that the program will continue on its present basis through additional contributions.

In selecting the cases that might possibly benefit by surgery, the records of 1400 people were examined, and from these, 332 were selected whom we believed offered hope of sight restoration. In order to examine and study this group of cases completely, 658 clinics were held to pick further from this number those that the surgeons felt could be offered treatment. As a result of this, the number of operations has totaled 120, and the number of hospitalizations has been 125, the additional five being for postoperative complications that developed, which needed re-admission for treatment.

The following is an analysis of the surgical procedures carried out.

CATARACTS

The number of cataracts totaled 41. Of this number, 25 per cent were known to be complicated or secondary cataracts before operation, and consequently the general pattern of the extraction had to be altered to meet the situation. This is a rather high percentage of such

cases but in such a group of patients it should be expected as many had previous eye diseases of an inflammatory nature, and others had been subjected to surgery with poor results so that further surgery was discouraged. As a result, this organization contained many who considered themselves hopelessly blind. In connection with this, it is interesting to comment on a case of uncomplicated senile cataract that came to the attention of the examining doctors. On questioning this patient it was found that some twenty years before he was told that cataracts were developing but that he was not ready for surgery, and he was advised to wait for a while until the cataracts became more advanced. His deficiency in vision led him to the Society for the Blind and he became taken up in their activities and the nature of his visual handicap forgotten. In one of the clinics when we first saw him, his condition was recognized and after assuring him that he had waited much more than a sufficient time, namely twenty years, he was operated for mature senile cataracts, and is now at work as a machinist.

In general, it may be stated that the results of the cataract surgery were good, at least comparable to any similar group of cataract patients.

IRIDECTOMIES

The number of iridectomies totaled eighteen, of which eight were optical iridectomies, and ten were preliminary iridectomies. Five received sufficient benefit so that further surgery was unnecessary. The remaining three cases had corneal transplants. Of the ten preliminary iridectomies, six were done before corneal transplants, and the other four were done before lens extraction as these cases presented secondary cataracts with synechia.

DISCISSIONS

Seventeen needlings were performed, all of which were necessary as the result of extracapsular lens extraction.

KERATECTOMIES

Six operations for superficial keratectomy were performed. On all of these patients, the operation was done as a preliminary procedure before corneal transplant. The superficial vascularized layer of cornea was removed in the usual manner in areas ranging from one quadrant to the entire area of the cornea. In all of these cases, Beta radiation was begun after forty-eight hours. This was applied to the limbus adjacent to the area of cornea operated, and in all cases it was effective in preventing the invasion of newly formed blood vessels.

ENUCLEATION

One case requiring enucleation for absolute glaucoma was brought to the attention of the Society for the Blind. This was uneventful.

One repair of an almost complete symblepharon of upper and lower lids was carried out. Satisfactory cul-de-sacs were restored without transplanted mucous membrane by the method outlined by Castroviejo. In brief, this consists in dissecting the superficial corneal layers above and below back beyond the limbus, and suturing the free edge to the limbal region. The cul-de-sac was restored by the freed mucous membrane and sutures drawn through to the skin.

OPERATIONS FOR GLAUCOMA

This group consists of four trephine operations, four cyclodialysis operations and one procedure for iris inclusion. These operations for glaucoma represent only five patients. One case, it is interesting to note, had five operations for chronic simple glaucoma before the intraocular pressure was satisfactorily controlled. This patient had two trephine operations, one iris inclusion operation, and two cyclodialysis operations. In spite of the extensive surgery, the eye is in good condition, and the removal of a cataract is contemplated. The other cases consisted of four trephine operations, two of which were in preparation for cataract extraction where chronic, simple glaucoma was also present.

CORNEAL TRANSPLANTS

Twenty-seven corneal transplant operations were performed in this group of cases, and of this number 80 per cent resulted in clear grafts. This figure corresponds quite closely to other authors on the subject. An analysis of the operated cases is as follows:

1.	Interstitial keratitis due to syphilis	8
2.	Interstitial keratitis due to tuberculosis	3
3.	Interstitial keratitis of unknown etiology	3
4.	Gruenows' Dystrophy	2
5.	Corneal leukomas	10
6.	Post-cataract uveitis and keratitis	1
		27

You are all acquainted with the usually accepted method of corneal transplant, so the details of the operative procedures will not be gone into in detail except to comment on the operation performed on the aphakic eye.

The donor material for this short series of corneal transplants was obtained both locally and from the Eye Bank for Sight Restoration, the latter organization very generously supplying corneas within a short time following the request.

The corneal transplant operation, when done on the aphakic eye, presents a special problem in procedure which the author would like to outline. This was carried out on one case in this series. The method as described here will appear in a forthcoming edition of the *Archives of Ophthalmology.*

In general, the corneal transplant operation

can be performed successfully on the aphakic eye, but it presents special problems, both in regard to the technique employed, and in regard to the surgical judgment in selecting the cases to be operated.

These cases can be divided into three groups:

1. Clear corneas that become opaque after the cataract operation has been done.

2. Corneal scarring due to keratitis following postoperative uveitis.

3. Cases presenting both an interstitial keratitis and mature cataract wherein the cataract operation was done first and the resulting vision was not as good as had been anticipated.

In cases showing both corneal leukoma and cataract, wherein it has been determined beforehand that the cataract does exist, it is a much simpler and safer procedure to carry out the corneal transplant first and the cataract extraction later, after a clear central area of cornea has been obtained. When the operations proceed in this order, the corneal transplant offers no special problems.

However, when the surgery is carried out in the reverse order, or the cataract is removed first, the operation will progress without complications until the anterior chamber has been opened and then there will be an overwhelming loss of vitreous. This fact has been recognized for many years and reported in the writings of Rycroft and Somerset, Filitov and Elschnig. If the lens has previously been removed there must be something in its place to keep the posterior segment intact, or as nearly intact as possible. To remedy this, Filitov devised a spatula for inserting into the anterior chamber to hold back the vitreous. However, this spatula requires a counterpuncture in the cornea which is not desirable, and it does not possess a curve that approximates that of the cornea, thus to seal off the opening more securely when grafting. In order to remedy these two factors, the author devised the following instruments, which consist of:

1. Two spatulas or blades having an average corneal curve with rounded ends and measuring six and seven millimeters in width, and fourteen millimeters in length.

2. Holder for spatula having flat, grasping surface and easy release mechanism.

3. Magnet for stabilization of blades.

4. Special six and seven millimeter keratomes.

In brief, the technique of the operation is:

After preparing the central area of cornea for grafting through the stage of inserting the sutures, the special keratome is inserted at the limbus parallel to the proposed area for grafting. The spatula is then inserted and carried to the opposite limbus where it is fixed and held securely to the posterior surface of the cornea by means of the magnet. The area that will be replaced by the transplant is removed and the graft inserted. The sutures are drawn over in the usual manner and the spatula is removed. The latter incision is closed by a silk suture.

The advantages of this instrument can be enumerated as:

1. Ease of management.

2. No counter puncture necessary.

3. The curve of the spatula more or less simulates the corneal curve which tends to block the opening.

4. The blades or spatulas that are introduced are of the same size as the keratomes so that the fit is tight and prevents leakage of vitreous through this opening.

In such a small series of cases the complications were very few, and those usually seen will not be discussed here as you are all acquainted with these problems and the methods of dealing with them. Three cases of postoperative iritis developed that required hospitalization and treatment. All healed satisfactorily.

However, two of the cases presented a complication not frequently seen, namely corneal fistula, and the author would like to discuss the method of handling this problem. One of the fistulas was very small, and closed following several cauterizations with iodine. This is the accepted method of treating such a complication, and in the smaller fistulas it is usually successful. Let me emphasize here the need for prompt action and closure of these draining sinuses. Failure to do so predisposes the eye to an increase in intra-ocular tension by the development of synechia, and closure of the filtration angle. The other fistula was quite persistent and large enough to require special consideration for closing. This larger fistula resisted the above method of closure, and consequently another method had to be resorted to. To close this, the edges were curetted and a small piece of mucous membrane was transplanted to the fistulous area and sutured securely to the area. This acted as a scaffold to allow fibrosis and resulted in complete closure.

CONCLUSION

In conclusion, it should be stated that the Secretarial and Social Service Departments of the Cleveland Society for the Blind deserve and are given, a great deal of credit for their untiring and faithful service in obtaining and handling the patients, and in processing and keeping the vast amount of data necessary in carrying out this program. Appreciation is also expressed for the financial support without which this project could not have been undertaken.

A Case of Proven Systemic Histoplasmosis With Apparent Recovery

VALERIE FRIEDMAN, M.D., J. E. BROWN, JR., M.D., and E. V. TURNER, M.D.

HISTOPLASMOSIS is a fungus disease caused by Histoplasma capsulatum recognized in man in essentially two forms. The usual form is a subclinical pulmonary infection which on healing leaves areas of calcification similar to healed lesions of tuberculosis.[1] Healing is also accompanied by a skin sensitivity to histoplasmin which is analogous to the sensitivity seen in tuberculosis. In some areas in the Midwest this type of infection is acquired by over half the population.[2]

A rare form of the disease which is seen especially in infants and children is characterized by widespread systemic involvement and has been thought to be uniformly fatal. Only recently has the survival of patients with the latter form of the disease been recognized (Bunnell and Furcolow, three cases[3]—Blumberg, one case[4]). The following case report represents another instance of non-fatal systemic histoplasmosis.

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CASE HISTORY

J. H., an 8-year-old white boy, was first admitted to the Columbus Children's Hospital, August 13, 1948, with the complaints of fever, headache, and general malaise of four days' duration. Family history, past history, and functional inquiry were non-contributory.

This patient lived on a farm and drank pasteurized milk and tested well water which had been reported "safe" for drinking. He occasionally played in a creek draining sink and bathtub water. He had a dog and a horse and played among chickens.

He was well until June, 1946, at which time he developed "mumps." Following this infection he had a continuous low grade fever which lasted until early fall of 1946. The fever was unexplained, tuberculin skin test was negative, and roentgenograms of the chest were essentially normal. The following winter he was in apparent good health. For the past two years the patient has had an occasional attack of croup occurring always at night and relieved with steam inhalation.

Early in June, 1947, he had an attack of bloody diarrhea diagnosed as amoebic dysentery. Apparently amoebae were found on one of several stool examinations.

Following this he was again in apparent good health until June, 1948, when he had an illness characterized by a week of irritability followed by a week of anorexia, fever, listlessness, headache, and abdominal cramps with ingestion of food or liquids. A second identical attack occurred in July, 1948. A third similar attack, which led to his admission to the hospital, had its onset about August 3, again with a week of irritability followed by fever (102°-105° F.), anorexia, and cramps with the taking of food or liquids.

On physical examination we were presented with a well-developed, well-nourished, white boy appearing his stated age of eight years. He was listless and lethargic. There was a pinched look about his facies, and he was complaining of frontal headache. The temperature on admission was 102.4° F., pulse 100; blood pressure 100/80; respirations 24. Cervical, axillary, and inguinal lymph nodes were small, "shotty," nontender, and were not felt to be enlarged. No other lymph nodes were palpable. Eyes, ears, nose and throat were essentially normal. The chest was symmetrical and resonant to percussion; expansion was equal on both sides. On auscultation there was an area of depressed breath sounds on the right from the midscapular area to the base posteriorly. No rales, rhonchi, or adventitious sounds were heard. The heart was of normal size, it was regular in rate and rhythm, and no murmurs were heard. The abdomen was flat, and over the right quadrant it was tender with some voluntary splinting. The liver was not palpated. The spleen edge was barely palpable and was very tender. The remainder of the physical examination was essentially normal. Our admitting differential diagnosis was: (1) Salmonella infection; (2) undulant fever; (3) pneumonia.

The results of laboratory examinations on admission were as follows: Urinalysis: 4 plus acetone, 8-10 WBC/H. P. F. Serologic test for syphilis was negative. Agglutination test for heterophile antibody was negative. Agglutina-

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tion tests for Typhoid O, H, Paratyphoid B, Proteus 0x19, and Brucella were also negative. No parasites or ova were seen in repeated stool examinations. Blood count: Hemoglobin 13.1 gm. per cent; white blood count 9,750, 60 per cent Neutrophils with a shift to the left.

By the fourth hospital day the lymph nodes which had been palpable on admission had enlarged, and epitrochlear nodes were now palpable. Two successive blood cultures taken shortly after admission revealed no growth. The child at this time had the appearance of one in acute respiratory distress, namely, pinched facies and extreme flaring of the alae nasi with inspiration. Because of this appearance a roentgenogram of the chest was made. This showed widely dispersed, mottled and streaky infiltration throughout both lung fields more dense in the bases and hilar regions which faded off to the periphery. There was knotty enlargement of both hilar regions, and a small amount of fluid was present in the right base. Interpretation by the roentgenologist was as follows: "The changes which are present could be on the basis of simple virus pneumonia. The possibility of tuberculosis and histoplasmosis along with other types of fungus diseases are to be considered in the differential."

Patch test, intradermal test with weak and strong tuberculin (PPD) were negative. Intradermal histoplasmin test was strongly positive in twenty-four hours. Cold agglutination test was negative. The presumptive diagnosis was now histoplasmosis.

It was at this time that the child's first cousin, his constant companion, a 5½ year old boy, was admitted with essentially the same history and physical findings.

The entire first week in the hospital the patient had a septic type of fever with one or two daily spikes to 104° and 105° F. Starting on the eighth hospital day the temperature spikes gradually decreased, and the temperature returned to normal by lysis at the end of the second hospital week. The lymphadenopathy gradually became more pronounced, but at no time were the lymph nodes tender. The spleen gradually enlarged to two fingerbreadths below the costal margin. A peculiar feature was noted that the abdominal tenderness, especially over the spleen, was present only during elevations in temperature. Anorexia was pronounced during the first week of hospitalization. The diet was reinforced with eggnogs and milkshakes, and the patient was treated symptomatically. He never coughed, and there was considerable difficulty in obtaining sputum for analysis and culture. However, from the time of admission to about the eighth hospital day his breathing was shallow, and there was flaring of the alae nasi. On or about the eighth hospital day he began to show clinical improvement in that he ate better, seemed more alert, sat up in bed and played, and both his appetite and general disposition improved amazingly. The lymphadenopathy and splenomegaly persisted throughout the hospital stay.

Since the diagnosis of histoplasmosis was merely presumptive, during the second week the child was treated with intramuscular penicillin and streptomycin. Streptomycin was also given by inhalation.

On the seventeenth day of incubation the initial blood culture demonstrated organisms which were tentatively identified as Histoplasma capsulatum. This was later confirmed in the laboratories of Dr. Samuel Saslaw of the U. S. Army Medical Center, Washington, D. C. Dr. Saslaw also reported that histoplasma complement fixation antibodies were present in a titer of 1:1280 and the histoplasma collodian agglutination test was positive in a titer of 1:320.

Another blood culture which had been taken on the twelfth hospital day also demonstrated the organism. Attempts to isolate the fungus from the bone marrow and sputum were unsuccessful. X-ray studies of the chest were repeated on the fifth, eighth, and fourteenth hospital days. They showed little change.

The patient was discharged home on the fourteenth hospital day to remain at absolute bed rest and to receive a reinforced diet. He remained at home two weeks and gained four pounds. He was readmitted because of a recurrence of fever. Positive objective findings on the second admission were: (1) "shotty" cervical, axiliary, and inguinal nodes with palpable epitrochlear nodes; (2) spleen-hard, nontender, palpable two fingerbreadths below the left costal margin. Laboratory findings were as follows: Urinalyses normal: white blood count 7,600; hemoglobin 11.3 gms.; polys 44 per cent with a shift to the left; 39 per cent lymphs; 12 per cent eosinophils; 5 per cent monocytes. Blood, stool, and a lymph node were cultured for histoplasma, but no organisms were isolated.

The patient did not appear as ill as he had during the first hospitalization. He was not as apprehensive; his appetite had improved considerably; he was alert and very cooperative. His temperature which was 101.4° F on admission gradually returned to normal by the fifth hospital day and remained normal. He was again given aerosol inhalations of streptomycin and penicillin. On the ninth hospital day under a general anesthetic three small lymph nodes were removed from the right inguinal area. Microscopic sections of the lymph nodes revealed focal areas which had the appearance of granulomatous lesions. These areas contained organisms morphologically identical with Histoplasma capsulatum.

The child was discharged home on the twelfth hospital day improved. The size of the spleen had not changed; however, the epitrochlear nodes were no longer palpable, and the other lymph nodes had decreased in size.

Since discharge he has remained afebrile; he has had no complaints; his appetite has been good, and there has been a satisfactory gain in weight. X-ray examination of the chest one, two, and three months after discharge have shown first a clearing of the patchy infiltration in the periphery and recently calcification has become evident in the left hilar glands.

The patient's cousin, whom I briefly mentioned, was also proven to have histoplasmosis. His subsequent course has been equally satisfactory. He has grown in stature and had an excellent gain in weight. Roentgenograms now show only hilar widening.

DISCUSSION

Generalized histoplasmosis in our patient was characterized by fever, pulmonary infiltrations, lymphadenopathy, splenomegaly, malaise, anorexia, vague gastro-intestinal complaints, and leucopenia. Other cases have been reported which in addition demonstrated hepatomegaly,

diarrhea, jaundice, and anemia.[5] Examples of this infection have been reported in children as young as two and three months.[4]

In our case the occurrence of a negative tuberculin test and positive histoplasmin test indicated the subsequent steps in investigation. In some cases, however, the histoplasmin test can remain negative in the face of a severe histoplasma infection.[3] Even the serologic tests (complement fixation and collodion agglutination) may become negative in long standing infections.[6]

The crucial diagnostic proof lies in the isolation and identification of the organism from the blood, bone marrow, sputum, or gland biopsy. It may be mentioned that since it takes from two to three weeks for histoplasma to grow out, routine cultures in most laboratories would have been discarded before growth could be expected. Methods for the isolation of histoplasma have been discussed by Howell.[7]

It should be noted that the original pulmonary infiltrations were merely suggestive of mycotic infection and that the calcifications were evident only after convalescence was well established. While this patient displays pulmonary calcifications on healing, it does not follow that the large number of histoplasmin reactors with pulmonary calcifications have had a similarly severe illness in the past. Indeed, stories of such illnesses have been extremely rare in the individuals who have been discovered by surveys to have pulmonary calcifications and negative tuberculin and positive histoplasmin skin tests. This is the basis for the assumption that the infections which bring about this roentgenologic and immunologic picture are subclinical in nature. Here again the analogy to tuberculosis is quite evident.

Various therapeutic agents have thus far been unsuccessful in the treatment of histoplasmosis. We feel that in no way did the antibiotics we used affect or alter the course of this patient's illness.

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The Story Behind the Word

Some Interesting Origins of Medical Terms

Hospital—This term is derived in English from the French term "hospitale," which was a large house or palace where a guest was received. Also from the Latin noun "hospes," meaning a guest or host or an entertainer or receiver of guests. Similar in derivation are the words host, hostel and hotel. It may be well to remember that by derivation hospitals are hosts or hotels for the receiving of the sick.

Nurses—This term comes to us from the Latin "nutria," meaning to suckle or feed—to care for the young—to mother. Literally meaning "a mother to the sick."

Uvula—This anatomical term for the small fleshy mass hanging from the soft palate derives its name from the Latin word "uva" or grape. It was so called from its fancied resemblance to a small grape.

Quassia—Said to be so called after a Negro named Quassy, who first discovered its medicinal qualities. It is a South American shrub whose wood is extremely bitter.

Plague—Literally this term means a blow. It is derived from the Greek word "plege," a blow, and "plessein," to strike.

Consumption—A name descriptive of the course of the disease coming from the Latin word "consumere." It literally means to consume, or to wear away.

Tuberculosis—Sylvius first applied the term "tubercle" to the typical nodular lesions he found at post-mortem, and from this grew the term "tuberculosis." Tuberculosis is a hybrid word, part Latin and part Greek. It is derived from the Latin "tuberculum" and the Greek "phymatosis." "Tuberculum" or "tubercle" means a swelling or nodule. Phymatosis derives from the Greek "phyma," meaning a growth or tubercle, and the Greek suffix "sis" which is used in forming verbal nouns and denotes a process of possession.

Cocaine—This word comes into our medical vocabulary from the Spanish word Coca, which in turn is derived from the Aymara Indian word "khoka" signifying "the plant." It was frequently called the "Divine Plant of the Incas" and the leaves had long been chewed by the natives of Chile, Peru, and Bolivia to relieve hunger and fatigue.

Catgut—The term "catgut" is supposed to be a perversion of "kitgut," or "kitstring;" the Arabic word "kit" meaning a dancing master's fiddle. However, it is probable that at some time "kit" was misconstrued as "kitten"; thus conveying the meaning of a young cat, and thence the word "catgut."

—Harry Wain, M.D., Mansfield, Ohio.

Pneumococcic Meningitis: A Case Report—Complications, Treatment, and Recovery

ROBERT E. SLEMMER, M. D.

THE mortality in pneumococcic meningitis was 100 per cent[1] prior to the use of chemotherapy. This was reduced to 80 per cent when sulfonamides were used[1] and further reduced to 40 per cent[2] after the discovery and use of the antibiotics, notably, penicillin.

It is suggested that the mortality will be further reduced when treatment is begun earlier using much larger doses[3] of penicillin alone.

The following case history is presented in detail.

The Author

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CASE REPORT

R. R.-483-950.

A nine-year-old white male was admitted to the Neurosurgical service of Drs. LeFever and Secrest at White Cross Hospital on the evening of May 21, 1948.

His chief complaint was nausea, vomiting and stiffness of his neck.

The history of his present illness revealed that he was in apparent good health until 2:00 a.m. the morning of admission, when he suddenly awakened, vomited, and complained of pain in his left ear. He became progressively worse until evening when he became delirious.

A review of his past medical history, as related by his mother, revealed that he had been delivered spontaneously after a prolonged labor. There had been considerable difficulty in getting him to breathe.

When he was three weeks of age an assymetry was noted in the frontal regions, the right being more prominent than the left. His mother also stated that there had been difficulty in getting him to swallow since birth.

At seven weeks of age he was admitted to the neurosurgical service at White Cross where examination revealed a marked bulging in the right frontal region. Phenolsulfonphthalein tests were done. These revealed normal kidney excretion. Following this neutral phenolsulfonphthalein (Dandy) was introduced into what was thought to be the right lateral ventricle. There was a marked decrease in the excretion of the dye. The diagnosis of a localized cystic arachnoiditis was made.

A right frontal craniotomy revealed an agenesis of the right frontal lobe (pole). The left frontal lobe was visualized beyond the falx. He made an uneventful recovery.

He walked at two years of age and started to school when he was six. It was soon discovered that the vision in his right eye was impaired. In spite of this he did well and demonstrated above average accomplishment in his school work.

Except for measles, chicken pox, and appendicitis (1947), he was well until his present admission.

Physical examination revealed a well-developed, well-nourished white male lying uncomfortably in bed, moaning and crying. His temperature was 97.3, pulse 102, and respirations 20. Cervical adenopathy was present. Examination of the heart, lungs, and abdomen were normal.

Neurologic examination revealed that he was semi-conscious. Muscle power could not be tested. The deep reflexes were bilaterally equal and somewhat increased. The superficial reflexes were present although diminished. There were flexor responses on plantar stimulation. Funduscopic examination revealed optic atrophy on the right and engorgment of the veins around the disc on the left. There was slight nuchal rigidity present.

Lumbar puncture revealed a pressure of 380 mm. of water with milky spinal fluid. Smear and culture revealed pneumococci.

Penicillin "G" (20,000 units) was injected intrathecally at the time of the initial puncture. Eight subsequent injections were made intrathecally by barbitage.

Admission urine examination revealed 20 mgm. of albumin and 1.4 gm. of sugar. Blood examination showed 13.9 gm. of hemoglobin, 4.9 million red cells. The white count was 19,400 with 89 per cent neutrophiles, and 11 per cent lymphocytes.

Treatment consisted of sulfadiazine, 1 gm. every four hours and penicillin, 300,000 units intramuscularly, daily.

X-ray of the chest the day after admission revealed an acute interstitial pneumonitis.

COURSE IN THE HOSPITAL

Four hours after admission his temperature rose to 102. The pulse and respirations were likewise elevated. Daily lumbar punctures revealed elevated pressures, cell counts and proteins. There were periods of remission, both subjective and objective, followed by exacerbations. The temperature ranged between 101 and 104. After two weeks of elevated spinal fluid pressure his discs gradually became choked. One month after admission there was very little change in his condition.

The dose of penicillin was then increased from 300,000 units to 3.6 million units daily. The morning of the third day after the increased dosage of penicillin the temperature, pulse, and respirations abruptly became normal and remained so

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for the remaining month of hospitalization. The choking of the discs promptly subsided.

On July 14, 1948, a bilateral sixth nerve palsy developed, accompanied by a return of increased pressure and choking. The right pupil dilated and did not react to light. A right frontal abscess was suspected.

Bifrontal burr openings were made. On the right there was a marked increase in pressure. There was a pseudo-membrane immediately beneath the dura which was grossly and microscopically an inflammatory exudate. Beneath this was a cavity filled with cloudy fluid under increased pressure. The cavity was located at the site of the congenitally absent right frontal lobe. It was lined with a grayish membrane. This was completely removed exposing the cortex posteriorly.

Smear and culture revealed no organisms. Sections showed a suppurative process with extention into the arachnoid.

A few days after surgery the sixth nerve palsy cleared and the pupils were equal. They reacted to light.

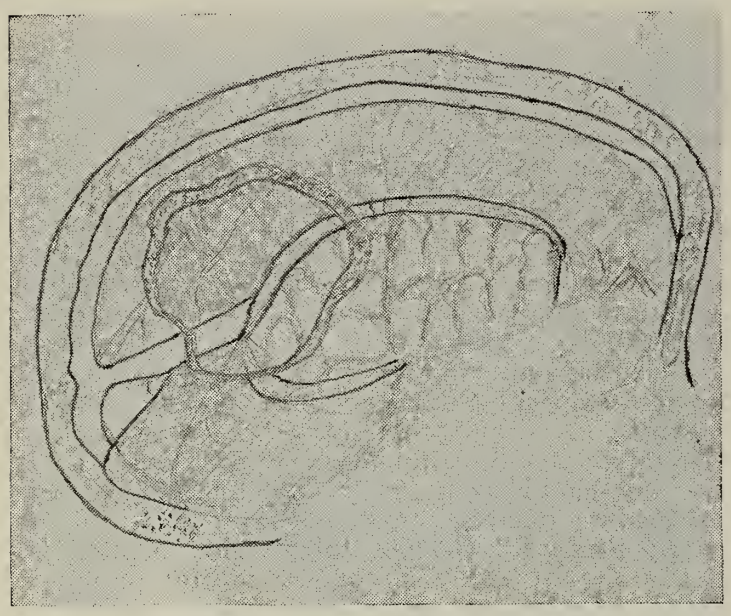


Figure 1

The patient was discharged, ambulatory, on the sixth postoperative day without complaints. He was advised to return in one month for encephalography.

Encephalography, using helium, was done on August 24, 1948. This revealed absence of the subarachnoid markings with filling of only the left occipital and left temporal horns.

On September 9, 1948, he was readmitted to the hospital with a chief complaint of headache.

His mother stated that three weeks prior to admission his writing had become less legible. On the day of admission his speech became jumbled and he became drowsy. He screamed with pain in his head and lost consciousness.

Examination revealed a spinal fluid pressure of 180 mm. of water. The fluid was clear and colorless. It contained 6 red cells and 10 white cells, 6 neutrophiles and 4 lymphocytes. Smear and culture were negative.

Neurologic examination revealed that he was semi-conscious. He had a right hemiparesis, right central facial weakness, and a dilated right pupil which did not react to light. His tongue protruded to the right. The abdominal reflexes were hypoactive on the right. There was an unsustained ankle clonus on the right with bilateral extensor responses on plantar stimulation and bilateral Oppenheim signs. The cremasteric reflexes were intact. Percussion and vibration in the right frontal parietal regions caused him to cry out with pain.

Laboratory examinations revealed 20 mgm. of albumin in the urine. Blood examination revealed 4.5 million red cells with 12.5 gm. of hemoglobin. The white count was 11,500 with a normal differential. The serum protein was 7.1.

On September 11, 1948, he was taken to surgery for ventriculography. On the left, the ventricle was entered without difficulty. On the right the dura was tough and thickened. Immediately beneath the dura there was a dense grayish membrane which could not be penetrated with a brain needle. This membrane was then incised. At a depth of 5 cm. a firm resistance was encountered. This was felt to be a tumor. The burr opening and dura were enlarged to approximately 5 cm. After removing the tough outer membrane the entire right cerebral hemisphere was seen to be compressed by a reddish gray mass which was from 1 to 1.5 cm. in thickness. It extended from the occipital region to the frontal region and from the midline to the base of the cranium. (Figure 1.) The whole mass was then removed, piecemeal, revealing that the entire hemisphere had been so compressed that mesially one could see the falx, superior and inferior longitudinal sinuses as well as the superior cerebral veins which were on a stretch as they drained into the superior longitudinal sinus. Posteriorly, the tentorium, transverse, and straight sinuses were seen. Anteriorly, the frontal region and space of the absent right frontal lobe could be visualized. The convolutions were extremely flattened, gray and opalescent.

Immediately after the removal of the mass the hemisphere began to expand. Spinal fluid could be seen flowing up over the convexity of the hemisphere.

Convalescence was uneventful. He was dis-



Figure 2

charged from the hospital on the ninth day after surgery.

He has been followed as an out-patient at regular intervals. He is doing very well with his school work. Except for optic atrophy on the right he has no residual symptoms.

PATHOLOGY DISCUSSION

The gross appearance of the mass at operation was that of a tumor, possibly a meningioma. The microscopic examination, however, revealed chronic inflammation, fibroblastic proliferation, and necrosis.[4 5 6]

Pneumococcal meningitis while usually associated with penumococcic infection elsewhere in the body, however, may precede infection elsewhere, as in pneumonia.[7] Chronic pneumococcic infections may organize and constrict.[8] This accounted for the compression of the right hemisphere. In addition to this, blood vessel changes occurred in the form of an arteritis and phlebitis



Figure 3

(Figures 2 and 3) in the late stage of development.[9]

Cairns and Russell described three stages of pneumococcic meningitis as found in autopsy material. The early or acute stage showed fibrinoid necrosis, the intermediate stage or stage of stagnation of pus and the late or final stage where they found proliferative vascular changes and endarteritis fibrosa with thrombosis.

TREATMENT

A combination of sulfadiazine (89.5 gm.), intrathecal penicillin (180,000 units), and intramuscular penicillin (62,415,000 units) were used.

Formerly the combination as used in this case was the accepted treatment.[2 10] More recently, in fact during the treatment of this patient, an exhaustive report[3] indicated that it was not necessary to use the combination. In addition, the intrathecal use of penicillin was contraindicated. In the same paper it was pointed out that the present dosage was much too small.

It was true in this case that when the dose of penicillin was increased to 600,000 units every two hours the meningitic symptoms stopped abruptly. One could theorize that had the larger doses been used early, perhaps, the intracranial complication might not have occurred.

SUMMARY

A case report is presented of an organized pneumococcic meningitis which occurred in a nine-year-old boy with a known agenesis of the right frontal lobe who recovered following the use of massive doses of penicillin and operative removal of an organized fibroblastic constricting intracranial mass.

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The Hollow Needle

This needle has been a mixed blessing. It must bear the responsibility for spinal anesthesia, and for a number of procedures that substitute blind chemical destruction for clean anatomical removal, such as the injection treatment of veins, haemorrhoids, hernia, hydroceles, ganglia, bursae and other local swellings. On the other hand, it has allowed the intravenous administration of fluids—a method that may be life-saving, but one that is greatly misused today. Some people never seem able to allow their patients to use the channels designed by nature to receive nourishment and to evacuate waste. Food and fluids given by the alimentary canal allow the tissues to select and keep what they want, and to reject what is harmful or surplus to requirements. Fluids given intravenously bypass all the defences set up by the body to protect itself against excess of any constituent, against bacterial entry, against thermal, chemical, or physical damage; they give the patient what the surgeon thinks his tissues need and what they are damned well going to get. Nearly all drips set up at the start of an operation are not merely unnecessary but harmful. At least half of the drips set up afterwards are an automatic routine or an assurance against worry rather than a considered form of therapy.—Sir Heneage Ogilvie, K.B.E., British Medical Journal, No. 4629, September 24, 1949.

Tuberculosis Abstracts

A Review for Physicians Issued Monthly by the National Tuberculosis Association

WADE HAMPTON FROST in 1937 presented a thoughtful appraisal of the question "How Much Control of Tuberculosis?" After marshalling the available evidence, he concluded that in this country we had already reached a stage at which the biological balance was against the survival of the tubercle bacillus and that eventually this disease would disappear.

A British opinion of the same year was: "It is idle to speak of the conquest of tuberculosis; tuberculosis has not been and so far as one can see never will be conquered." This opinion was endorsed recently by Medlar who found many tuberculous pulmonary lesions unrecognized during life in persons in the older age groups coming to autopsy in New York City.

The question of the validity of Frost's thesis is of great practical as well as theoretical importance. His reasoning was briefly this: There were many and sound reasons for doubting that the rapid decline in tuberculosis in the preceding half century had been due principally to the measures which had been taken for the purpose of preventing infection. Without question the factors lumped together under the terms "advancing civilization and better living conditions" had played an important role. There was reason to believe, however, that the decline was due in some part to the efforts made to control the disease.

The direct attack has proved to be a more formidable undertaking than was at first realized, but in Frost's words: "If the effective control of tuberculosis required complete isolation of all open cases, . . . the present (i.e., 1937) status could not be considered encouraging, for . . . (many) such cases are discovered in a fairly advanced stage, and the isolation even of cases known to the authorities is probably less than 50 per cent complete. However, for the eventual eradication of tuberculosis, it is not necessary that transmission be immediately and completely prevented but only that the rate of transmission be held permanently below the level at which a given number of infection-spreading cases succeed in establishing an equivalent number (of 'open' cases) to carry on the succession. If the number of infectious hosts is continuously reduced, the end result . . . must be extermination of the tubercle bacillus."

He placed a single qualification upon his conclusion that "As to the maintenance of this balance, favorable to us, unfavorable to the tubercle bacillus, there are, of course, elements of uncertainty, among them uncertainty as to the stability of our civilization."

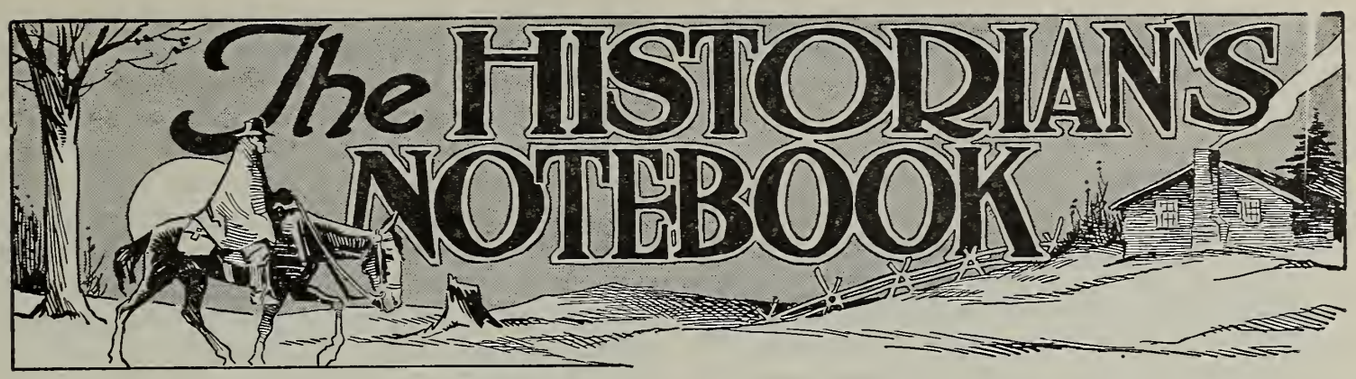
Only 12 years have passed—too short a period upon which to base inferences in regard to long-time trends—during which the very existence of civilization has been threatened. The world has undergone one of the greatest military, social, and economic upheavals in history. It is, therefore, pertinent to review the experience of this decade and inquire whether the Frost thesis is still tenable.

Despite their limitations, mortality rates provide the best available index of the biological balance over long periods of time. During the war years, mortality from tuberculosis increased in most of the western Europe nations involved in the conflict, while those countries that escaped the rigors of war were little affected. In western Germany the rate is still higher than in 1938. In Belgium and the Netherlands, as in England and France, the rate rose during the war, but by 1946 was already down to or below the 1938 level. In Denmark, Sweden, Switzerland and the United States, mortality continued downward during the war.

It appears, therefore, that the disturbances due to the war have been insufficient to effect more than a temporary setback in declining death rates. It would appear then that, where civilization is relatively advanced, the biological balance is still against survival of the tubercle bacillus.

To what extent this is due to indirect socio-economic causes or indirectly to control measures is still a difficult question to answer. In the United States, progress has been made toward more effective measures of control despite the war. In the field of specific therapy the most important contribution was, of course, the discovery of streptomycin which is now receiving extensive clinical trial. Experience with it thus far gives hope that eventually an antibiotic may be discovered which will suppress growth of the microorganism in the tissues and rapidly terminate the infectious state of pulmonary tuberculosis. With such an agent, the seedbed of the disease could be more rapidly reduced.

Granting continuation or strengthening of control efforts in addition to favorable socio-economic developments in a world at peace, it would seem not unreasonable to expect that the balance, favorable to us, unfavorable to the tubercle bacillus, will be maintained and that the decline in mortality from tuberculosis will be sustained, even to the point of disappearance from some areas. There is nothing in the record up to date that is inconsistent with Frost's thesis. *Is Area Eradication of Tuberculosis Possible? Editorial, American Journal of Public Health, June, 1949.*



The Proceedings of the General Medical Society of Ohio in 1829

ROBERT G. PATERSON, Ph. D.

AN item of extreme rarity has recently become the possession of the Committee on Medical History and Archives of the Ohio Archaeological and Historical Society. It is the "Proceedings of the General Medical Society of Ohio" held in 1829. Mrs. Deitchman, widow of Dr. Louis S. Deitchman, now of Los Angeles, California, and formerly of Youngstown, Ohio, is the donor of the gift.

If one needed a justification for the labors of the Ohio Committee on Medical History and Archives it can be found in the story of this gift from Mrs. Deitchman. In the January, 1938, issue of *The Ohio State Medical Journal*, there appeared an account by the present writer in The Historian's Notebook of the "Proceedings" under discussion.[1] The account was based upon a photostatic copy of the "Proceedings" secured from the only known extant copy held by the Army Medical Library, Washington, D. C.

Following this publication a letter was received from Dr. Deitchman of Youngstown stating that he possessed a copy of the "Proceedings" and giving an account of the manner in which he secured it.[2] He rescued it in a wastebasket that had been brought down from an attic. If he had not known what it was it would have been thrown away as trash.

In the May, 1938, issue of *The Ohio State Medical Journal* in The Historian's Notebook a more complete attempt was made by the writer to record the early history of medical organization in Ohio.[3] This account led Dr. Deitchman to write a detailed account of the "Proceedings." This appeared in June, 1938.[4] In this article Dr. Deitchman wrote, as follows:

> "The first meeting of the General Medical Society was duly 'holden' in Dec., 1827, in the town of Columbus, as Dr. Paterson states. Unfortunately the only reference to this meeting is found in the constitution of the society, which states that same was adopted in 1827 and is now, in Jan., 1829, amended. There is no mention of reading of minutes of the proceedings of the 1827 meeting or any other information. What a pity! Let us hope that somewhere there is a detailed record of this first meeting of the State Medical Association."

Dr. Deitchman, in this quotation, did not read carefully, or overlooked, a statement made in the May issue to the effect that the Ohio Committee on Medical History and Archives had acquired a copy of the "Proceedings of 1827."[5] This was secured from Goodspeed's Bookshop, at Boston, Massachusetts, and so far as present information reveals completes the printed records of all state medical organization held in Ohio.

The subsequent developments respecting the "Proceedings of 1829" may be of interest. As soon as our Committee learned of Dr. Deitchman's holding, correspondence was begun with him to have him deposit the "Proceedings" with the Committee. Then World War II intervened and Dr. Deitchman joined the medical service of the United States Army as a major in August, 1942. Upon his return in April, 1946, negotiations for the pamphlet were reopened. On September 4, 1946, he died of coronary occlusion at age 52. His widow faithfully carried out his previously expressed intentions.

The entire episode illustrates the profound truth of Pasteur's observation that "chance favors the prepared mind."

It seems quite fitting that this account should be written at a time when the Ohio State Medical Association is gathered in its 103rd annual meeting here in our city. Truly, the more than

Presented at the Sixty-fourth Annual Meeting of the Ohio State Archaeological and Historical Society, April 23, 1949.

7,400 physicians in Ohio stand upon the shoulders of the early pioneers of medical organization in Ohio as portrayed in the Proceedings of 1827 and 1829.

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Medicine 100 Years Ago

Professor Howard's Clinic of the Starling Medical College: Nov. 10, 1849, No. 21. B. W. E., age 3 years, from Columbus. For the last six months this little boy has had symptoms of stone in the bladder, suffering very much therefrom. Three weeks ago, on sounding, a small stone was detected. Through the consent of the parents, the little patient was brought before the class for operation. Complete unconsciousness and quiet sleep was induced by chloroform. While the child was in this state, Professor Howard cut for and removed the stone, within the space of three minutes. He (the child) was entirely unconscious of suffering, and did not experience, in the slightest degree, that constitutional shock so common and terrible after capital operation in surgery.

* * *

Number 24. M. D., age 13, male, Franklin County. Case—Chronic inflammation and thickening of the periosteum of the ulna, (one of the bones of the arm) five years' standing. The part affected is extremely painful, particularly at night, as is usual in all similar affections of the bones.

The doctor recommended rest and the persevering use of Iodide of Potassium, with the Emp. Ammon C. Hyder to the part.

* * *

Number 25. A. L., age 2 years, female, Pickaway County. Case—Strumous Ophthalmia, (scrufulous sore eyes). Has decidedly scrufulous diathesis. Suffers from great intolerance of light, yet but slight indications of inflammation of the eye.

Dr. H. assured the class that though this was very distressing and sometimes obstinate complaint, a specialty cure might be affected by nutritious food, exercise in the open air, purgatives and tonics.—*Ohio State Journal, November 12, 1849.*

* * *

No. 39. R., aged 3 years, Columbus. Case—Impetigo Figurata—on the scalp, neck and face. Prof. Howard made some remarks respecting the confusion in diagnosis of diseases of the skin growing out of their great numbers, and the strong resemblance between many of them and dwelt upon the necessity of becoming familiar with the leading characteristics of, at least, the more important classes. The case before the class was a pustular eruption, a very troublesome and loathsome disease, sometimes with difficulty distinguished from others of the same class. The proper treatment consisted in evacuants and correctives to the general health, with frequent ablutions and some preparations of sulphur, locally applied.

* * *

No. 41. B, a male infant from Columbus. Aneurism by anastomosis, (mother's mark) occupying two thirds of the upper lid of the eye. Growing rapidly. The professor alluded to several plans which have been adopted for the removal of these obnoxious and unsightly growths, which usually make their appearance upon the face. The seton, vaccination, caustic, etc., have been successively tried, but were generally unsuccessful. The actual cautery with hot needles, was now the most approved remedy for this disease. Three or four heated needles were passed through the tumor, in the present case, with but slight pain to the patient. The object of which was the ultimate obliteration of the vessels of which the tumor was composed.

* * *

No. 44. Mr. F., aged 45, from Delaware, Ohio. Case—Dislocation of the Elbow backwards; seven weeks' standing. Several unsuccessful attempts had been made, by a number of very respectable physicians, to reduce this luxation. Prof. H. stated that, in the course of twenty years, he had had a large number of these old dislocations of the elbow presented for reduction. Many of them he had attempted to reduce. In some of the most recent cases he had succeeded, but in no instance had he succeeded after the dislocation had been over three weeks' standing. The locking together of the bones—the resistance of powerful antagonistic muscles and the firm adhesions between the lacerated and displaced ligaments, all conspired to oppose reduction. At the urgent solicitation of the patient, whose daily bread depended upon the restored usefulness of his arm, the doctor consented to apply Jarvis Surgical Adjuster, in order to afford him a chance of success. The Adjuster was applied and extension kept up about an hour, while a portion of the time, the patient was under the influence of chloroform. Although the reduction was not complete, the patient has been able, since the operation, to flex the arm nearly to a right angle. Such has been the improvement that, notwithstanding his intense sufferings, he is anxious to submit to still another trial.—*Ohio State Journal, Tuesday evening, Dec. 4, 1849.*

The General Practitioner and the Hospital Staff

EDWARD J. McCORMICK, M.D.

THE general practitioner is the supporting structure of all medical practice. Only the uninformed could possibly take exception to this statement. Eighty per cent of the practice of medicine is in the hands of doctors in general practice, who serve loyally night and day at the bedside, in the home and in the office consulting room. There is no more heroic saga of service to humanity by any group of men or women which can surpass that of the rural or city physician, who has given his or her life to the health of the community in which they live and who recognize early in their careers that self-sacrifice in the broader field offers a greater satisfaction than the limited fields of specialization.

To be the family doctor, friend and counsellor on all subjects, a community leader and adviser places the practitioner of general medicine on a plane with those to whom the welfare of souls is entrusted. He is a well-trained medical man, frequently possessing a diagnostic sense which transcends the maize of modern complicated laboratory tests. He is trained in pediatrics, obstetrics and in emergency care and by contact as well as by study develops a knowledge of psychiatry which cannot be acquired except by the daily practice of general medicine and an intimate knowledge of the trials, tribulations and frustrations of his many patients and friends. His years of college and formal medical training make him a "standout" among his fellows of all vocations, because if he is a good family doctor, he has gained what many men have missed—a knowledge of his own limitations.

WELL-EARNED PLACE

This is not intended to be a eulogy for those in the field of general medicine but an attempt by one in a specialized field to accord to the deserving their well-earned place in the field of medical organization and to impress upon the profession and hospital executives that without general practice there can be no medicine in our present economy, and to carry to the public the thought that an unwarranted demand for specialty service results in an unnecessary high cost of medical care and may well be the seed and the root whence springs the present hue and cry for federalization of medicine, threatening our Democracy and free enterprise system.

Your narrator is not a neophyte in the problem of the relationship of the general practitioner to the hospital. It was with satisfaction, as an officer of the American Medical Association, that I participated in the establishment of the Section on General Practice in 1946. I recognized the desire of large hospitals at that time to establish general practice sections.

My own activity in the field antedates the birth of the section on general practice in the A.M.A. As Secretary and later Chief of Staff of a hospital of three hundred and fifty beds, I caused to be written into our constitution a section titled at that time "The Active Unassigned Staff." This change provided for staff and voting privileges for general practitioners excepting the care of staff patients and the teaching of interns and residents. These latter duties were accorded to the specialty groups in which the intern or resident was serving.

I am now of the opinion that teaching privileges should be given those general practitioners who can qualify in some special field and there are many who have, by work and study, become experts in various fields though not limited to any specialty.

At the present time we have many general practitioners on our active staff and our courtesy staff. The Secretary of our staff and of our Executive Committee is a general practitioner. These members are privileged to attend and participate in all staff functions and meetings. They may hold office and serve on committees. Directors of departments may make use of the talents of these men on active staff service if they so desire. The provisions of our constitution fifteen years ago and in its present form provide that a general practitioner may be elected to senior staff grade after a definite number of years of sevice, which roughly approximates the time required for the surgeon or other specialist to gain senior staff membership, which in the latter case is predicated on College membership or Board recognition in conjunction with a sufficient period

Delivered at the meeting of the Protestant Hospital Association, Cleveland, Ohio, September 24, 1949.

The Author

• **Dr. McCormick, Toledo, Ohio, is chairman of the Advisory Committee and a member of the Executive Committee of St. Vincent's Hospital, and director of surgery at Maumee Valley Hospital, Toledo. He is a Fellow of the American College of Surgeons, is a Past-President of the Ohio State Medical Association and is presently serving as a member of the Board of Trustees of the American Medical Association.**

of preceptorship and observation to satisfy all concerned that the specialist is competent and is actually limiting his work.

JUNIOR MEMBERSHIP

The constitution of our hospital fifteen years ago provided for Junior membership, a non-voting status wherein younger men who had not limited their work or obtained sufficient specialty training were permitted to work under supervision or preceptorship in various departments for a period of five years, during which time he or she was asked to obtain the necessary credentials for eventual Senior staff membership in the department to which he or she aspired, or step aside and eventually apply for membership on the unassigned active staff.

In its present revised form, Junior membership is eliminated to provide greater facilities for our resident teaching program, which we feel will provide a sufficient number of young men who will qualify for specialty positions. We have justified the elimination of our Junior staff in various specialties upon the fact that most of the young men who come to us for staff privileges have already had several years of hospital training and our volume of teaching cases is sufficient to train specialty residents but not large enough to give additional training to our younger practitioners. We also believe that a general hospital should not attempt to train general practitioners as specialists.

Many of the general practitioners on our Senior staff are former interns and junior residents. We shall soon have general practice residencies, as the building program now under way will enlarge our capacity to approximately five hundred beds.

PLAN MUTUALLY SATISFACTORY

We have found this plan, which I have outlined in a rather general manner, to be satisfactory not only to the hospital but to the general physician who is accorded recognition. As time goes on, we will no doubt make additional changes but after fifteen years of experience, we are certain that no mistake has been made. For the good of the public, the profession and the hospitals, the so-called "Closed Staff" should be relegated to the oblivion to which it belongs as far as the voluntary hospitals are concerned. If the general practitioner cares for 80 per cent of the sick, he is entitled to care for his patient in the hospital and seek consultation and help when he deems the same necessary. It also follows that if hospitals are to maintain teaching and special facilities that these should be available to the great majority of doctors, the heroes of general practice, and be not confined to interns or residents.

It is my observation and belief that those in the general medical field, having received the recognition to which they are justly entitled, grow in knowledge by contact and become more proficient, render better service to their patients and, because of professional association and advice, do not attempt to walk where "Angels fear to tread." While our consideration, in staff organization, of the general man may not be perfect, it has gradually developed over a fifteen-year period to a point where much has been gained in proper recognition of the family doctor.

VISIT TO JAPAN

In the summer and fall of 1948 I was fortunate in that I became a member of a medical group of five men invited by General Douglas MacArthur, to make a survey of the medical conditions in Japan. Our experiences on this trip by air across the Pacific and return, coupled with an exhaustive survey of medicine in Japan, was an education. One or two of our observations are presented to you now as having direct bearing on the relationship of the general practitioner to the hospital, although no parallelism can be drawn between American medicine and medicine in Japan or any other country where government monopoly has existed.

There were in Japan, at the time of the American occupation, 51 second-class medical schools known as Semmon Gakko Schools. The origins of these diploma mills were originally normal schools and were stimulated by the Japanese government contrary to the advice of the better element in the Japan medical profession. The idea was to produce a grade of doctor willing to practice in rural and occupied areas but not in Japan proper.

The number of graduates and political pressure eventually changed the original plan and these men, with some clinical lectures but no basic science experience or laboratory work or dissection, were permitted to practice in Japan.

REGULATIONS TIGHTENED

General MacArthur and Brigadier General Sams have closed some of these schools, others were put on probation and must reach university level or be eliminated. Certain of these schools were connected with 19 universities giving a second class medical course in addition to the regular university medical curriculum.

In 1945, 5,380, or 61.2 per cent of Japanese medical graduates were from Semmon Gakko schools. Had this continued until 1949, 8,870 would have graduated in 1949—76 per cent from second-class schools.

ARROGANT PEDAGOGY

Certainly the loss of the war was a boon to Japanese medicine. There was no intern or resident service in Japan. In the regular medical ranks there was an aristocracy of teachers and

researchers who looked down their noses at any practitioner and who "lost face" if any one could understand their lectures.

All hospitals were controlled by the government, prefectures, municipalities or certain groups. The staff was on full time, poorly paid and the general practitioner had no hospital connection and lost his patient on the hospital steps. As a result hundreds of three, four, five or six-bed hospitals were opened by doctors. The conditions in these hospitals were a challenge to American imagination and beyond your speaker's descriptive attainments. S.C.A.P. moved to close these institutions as rapidly as possible and to make available for qualified members of the profession the facilities of regular hospitals, poor though they were.

I narrate these observations to bring to mind the fact that monopoly and cliques whether in government, in hospitals, or in the profession, can have a deleterious and fatal effect on the aims and purposes of scientific medicine and the public health. Exclusion does not promote good medicine.

That hospitals should be centers for specialists only is not tenable. In our eagerness to raise standards of professional efficiency, we may at times have been blind to basic facts but it was never the idea of the American College of Surgeons or the Council on Medical Education and Hospitals of the American Medical Association to establish a system wherein 80 per cent of our medical personnel would be denied the advances necessary to give good medical care to the people.

FAULTY DIRECTION

The editorial page of *California Medicine* in one of its 1947 issues sums up the problem in these words, "The purpose of the American Medical Association and the American College of Surgeons has not been to elimiate capable doctors from staffs nor to concentrate the practice of medicine in the hands of a few. The fact that such a fault seems to be arising is rather the fault of administration and a failure to analyze and direct the hospital system."

The American Board of Surgery, in a resolution passed December 14, 1946, expressed itself as follows: "The American Board of Surgery is not concerned with measures that might gain special privileges of recognition for its certificants in the practice of surgery. It is neither the intent nor has it been the purpose of the Board to define requirements for membership on the staffs of hospitals. The Board specifically disclaims interest in or recognition of differential emoluments that may be based on certification."

E. H. L. Corwin, Ph.D., in his book, "The American Hospital," 1946 edition, P. 155, states: "In the future there will be no excuse to make a major hospital staff appointment from among any except those who have met the standards of their respective specialty boards." It is this attitude which has put capable general practitioners in a difficult position. I believe that it is not the attitude of those concerned with standardization and better medicine.

A.M.A. STAND

The House of Delegates of the American Medical Association on December 10, 1946, passed the following resolution:

"Resolved that hospitals should be encouraged to establish General Practitioner services. Appointments to a general practice section shall be made by the hospital authorities on the merits and training of the physician. Such a general practice section shall not per se prevent approval of a hospital for the training of interns and residencies. The criterion of whether a physician may be a member of a hospital staff should not be dependent on certification by various Specialty Boards or memberships in Special Societies."

Teaching institutions and centers should be the first to lead the way. Theirs is the duty of teaching sound medicine to all, not to a few. All of us interested in the future of medicine must lend our abilities to the creation of more and better general practitioners and de-emphasize specialization. The future of medicine in America will be determined by our immediate approach to this problem.

Those of us interested in doctor-hospital relationship must give earnest thought to the relationship of the general practitioner to the hospital. We must, of course, have a reasonable quota of specialists and consultants. I am sure, however, that the man or woman in general practice will be among the first to demand minimum requirements in the general practice field, which is the aim of the American Academy of General Practice. This group is demanding a certain number of postgraduate hours each year for the maintenance of membership in the organization. If this requirement is rigidly enforced, the Academy of General Practice will become a virile organization in the medical field and if it is neglected, the Academy will eventually "die on the vine" as progress in the field of general practice is the main reason for its existence.

It should be our aim and purpose not to exclude but to include in hospital staff organization those in non-specialized fields. They can gain not only greater standing by such affiliation but greater knowledge and the specialty groups, by contact with the general practice field, can develop broader horizons and appreciation of the problems of the general medical field.

IMPORTANCE TO PATIENTS

The real improvement, however, will be to the patients who will find available good medical service conveyed to them by men and women in

whom they have great confidence, the result of intimate contact. The great problem of medical cost will be partially resolved by more general and less specialized advice. Much useless expenditure will be prevented when the public learns that the medical thinking of our grandfathers was correct. Their first haven was the family doctor. Those who wander here and there, choosing first one specialist and then another upon the advice of friends and acquaintances, never accomplish much from a health standpoint in the final analysis. Nurses, hospital personnel and technicians are frequently devoid of any real knowledge of physician and specialist abilities. The one who does know is the family physician.

There is no one in the medical profession who has a greater claim on hospital recognition than the general practitioner. He or she does not desire to teach surgery or gynecology or radiology or any other specialty. Nor do they desire promotion above their merits and qualifications and such recognition should not be extended. There is, however, a great chasm between over-recognition and exclusion. Neither is justifiable. The betterment of the profession, the expansion of hospital and medical service to the public and the good of the public health from a scientific and financial viewpoint demand that those of us in the fields of standardization, hospital administration and specialty practice "Render to Caesar the things that are Caesar's." Never in the history of American medicine has such a course been more necessary than the present time, as it is conceivable that the fundamentals of American Democracy may hang in the balance.

Opinion of Attorney General

The syllabus of Opinion No. 926 of Attorney General Herbert S. Duffy is as follows:

"1. A general health district board of health may enact rules and regulations governing the quarantine of persons infected with a communicable disease.

"2. A general health district board of health may enact regulations governing the quarantine of tuberculosis patients.

"3. Whether a general health district board of health may impose a quarantine according to Section 4429, General Code, depends upon the reasonableness of the proposed regulation in respect to locale, prevalence of the disease, existing control measures and the fact and circumstances peculiar to the particular case.

"4. Under normal circumstances, in view of control measures now available, 'home quarantine' of tuberculosis patients, according to Section 4429, General Code, would seem arbitrary and unreasonable."

Veterans Administration

Veterans Administration announced the appointment of Dr. Harry H. Botts as manager of the Chillicothe, Ohio, V. A. hospital.

Dr. Botts formerly was manager of the V. A. hospital in Marion, Ind. Prior to that appointment, he had been manager of the Chillicothe hospital.

He succeeds Dr. Cecil B. Shrout who is retiring from his position as manager at Chillicothe after 32½ years of Government service.

* * *

Private dentists handled 84 per cent of the treatment cases completed during the fiscal year ending June 30, 1949, under the Federal program to treat eligible veterans for service-connected dental conditions.

A statistical report shows 430,271 treatment cases completed by private dentists and 83,372 by clinics located in V. A. regional offices.

In Ohio the records showed 4,396 treatment cases completed by V. A. staff dentists at a value of $245,749; 30,772 treatment cases completed by private fee-basis dentists at a cost of $2,878,038. Of examination cases completed in Ohio, 25,010 were by V. A. staff dentists at a value of $292,-719; 9,913 were by private dentists at a cost of $136,429.

* * *

Teams of doctors and other specialists, set up to improve the treatment and care of disabled veterans requiring artificial limbs, braces or other orthopedic devices, have been established in 25 cities, Veterans Administration announced.

The V. A. said that "Orthopedic and Prosthetic Appliance Clinic Teams" are operating on an out-patient basis and only for veterans with service-connected disabilities.

Twenty-three of the 25 clinic teams are operating in Regional Offices. The other two are in temporary quarters and will be moved to the Regional Offices in the cities where they are located as soon as space is available.

Veterans who are in need of the services of these clinics receive transportation to and from their homes to one of the nearest offices. Offices in the vicinity of Ohio are at Chicago, Detroit, Philadelphia, Pittsburgh, and Louisville.

* * *

Veterans Administration announced it has awarded a $6,985,905 contract for the construction of a 500-bed general medicine and surgical hospital in Chicago.

* * *

A recent survey showed that in every V. A. hospital in the nation some form of musical activity goes on regularly. Of 130 hospitals, 34 had full-time music specialists.



Here It Is 1950!

Time To Make
Hotel Reservations
for the
1950 Annual Meeting
Ohio State Medical Association
Cleveland, Ohio . . . May 16, 17, 18

NAME AND LOCATION	SINGLE	DOUBLE	DOUBLE TWIN BED
ALLERTON HOTEL, 1802 E. 13th St.	$3.50-6.50 $2.50 RW	$5.50-10.00	$6.00-10.00 $4.00 RW
AUDITORIUM HOTEL, 1315 E. Sixth St.	$3.50-3.75 $4.50-5.00	$5.50-6.00 $7.00	$7.50 and Up
CARTER HOTEL, PUBLIC SQUARE	$4.75-7.00	$7.00-10.00	$8.00-12.00
CLEVELAND HOTEL (Headquarters Hotel)	$4.50	$6.50-9.00	$9.00-14.00
HOLLENDEN HOTEL, 610 Superior Ave.	$3.50-8.00	$5.50-10.00	$7.00-14.00
OLMSTEAD HOTEL, Superior & E. Ninth	$3.00-6.00	$5.00-8.00 $7.00-9.50	$7.00-9.50
STATLER HOTEL, Euclid at E. 12th St.	$4.00-6.00	$7.00-10.00	$8.00-12.00

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Hotel, Cleveland, Ohio

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 16, 17, 18, 1950, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price .....

☐ Twin Bed Room with Bath ☐ Suite

Arriving May.....at.....A. M..... P. M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

.....

SECOND CALL FOR ENTRIES IN

Scientific and Educational Exhibit

1950 Annual Meeting, Ohio State Medical Association

May 16-18, Cleveland Public Auditorium

ONE of the outstanding features of the 1950 Annual Meeting of the Ohio State Medical Association, May 16-18, Cleveland Public Auditorium, will be the SCIENTIFIC AND EDUCATIONAL EXHIBIT. The exhibit held in connection with the 1949 meeting in Columbus was highly praised by members attending the meeting. Efforts will be made to make the 1950 exhibit even bigger and better than the one in 1949 and in previous years.

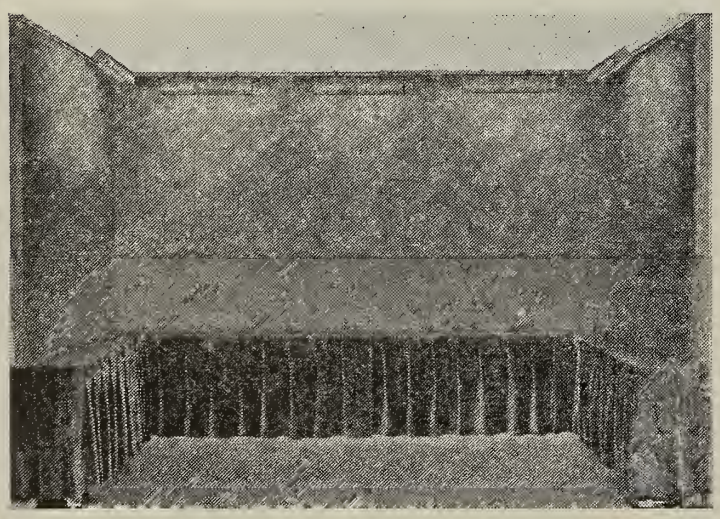
This is a general invitation to members of the Ohio State Medical Association to participate, as well as others who have display material which will be of scientific value and of general educational value to physicians.

Please note: Exhibit material does not have to be strictly scientific. If it presents data which will be of general educational value to the medical profession, it will be considered by the committee which has full authority to accept or reject applications at its own direction.

On the opposite page will be found an application blank. If you have material suitable for an exhibit, or know of some colleague or group of physicians having interesting material to display, send in an application and suggest to others that they do so.

The Scientific and Educational Exhibit will be in the same hall with the Technical Exhibit. This will be a grand break for both exhibits.

The firm which handles exhibits for the American Medical Association and which handled exhibits for the 1949 O. S. M. A. meeting—Advertising Displays and Decorations, Cleveland—will supply the equipment and supervise the erection of the exhibit. Equipment and facilities similar to that used at A. M. A. meetings will be used. **The accompanying picture shows the type of booth which will be provided.**



Type of Booth To Be Used for Scientific Exhibits

Booths will be of uniform color and design; solidly constructed of wood and wallboard; skirted with velour. There will be a shelf. The upper area will be covered with taut blue crash fabric for bulletin board background and will permit the tacking or taping of charts and specimens without fear of damaging the exhibits. Fluorescent lights are a part of the background.

APPLICATION

For Space in the Scientific and Educational Exhibit

1950 Annual Meeting • Ohio State Medical Association

CLEVELAND PUBLIC AUDITORIUM CLEVELAND, OHIO MAY 16-18, 1950

Fill Out and Mail to:

CHARLES L. HUDSON, M. D., *Chairman*
Committee on Scientific and Educational Exhibits
2102 Abington Rd., Cleveland, Ohio

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1. Title of Exhibit:_____

2. Description or nature of exhibit: (attach 200-word description to this blank).

3. Will radiologic viewing boxes be needed? If so, state number and size:

Number of boxes needed_____ Size required_____
(Please indicate if you plan to furnish own view box.)

4. Will you require shelf space? If so, how much?_____

5. How much floor space will you require?_____

6. How much back wall space will you require?_____

7. How much side wall space will you require?_____

8. Other material or equipment required:_____

9. Name of exhibitor:_____

_____ (Street) _____ (City)

10. Name of institution cooperating in exhibit (if desired):

_____

_____

Cost of transporting exhibits to the meeting must be borne by individual exhibitors as well as the costs of cards, signs, etc., which are a part of the exhibit.

The Ohio State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, view boxes, current, furniture, decorations, etc., providing all items are approved in advance by the chairman of the committee. Watchman service will be provided for the exhibit.

Problem of Malpractice . . .

Medical-Legal Authority Warns Physicians That Even Exercise of the Highest Degree of Skill and Care May Not Ward Off Unjust Claims

AS the author of this article states, "No physician is immune to a malpractice suit." The thorough discussion of the matter, therefore, will be of interest to Ohio physicians as well as to physicians throughout the nation. The author, Dr. Louis J. Regan of Los Angeles, is thoroughly competent as an authority on the subject since he holds degrees both as Doctor of Medicine and Bachelor of Law. The article is reprinted from the November 12 issue of *The Journal of the A.M.A.*

Malpractice constitutes a real threat to the members of all the healing professions. Doctors of medicine were attacked first and are still the primary targets. In 1937 about 4,000 of them were sued for malpractice in the United States. The plague spread to involve dentists, osteopaths, chiropractors, naturopaths, and nurses. Now, even veterinary surgeons are being assailed with malpractice suits with increasing frequency.

Public confidence in the medical professions is seriously affected by the ill will and misunderstanding engendered by these frequently unfounded and sometimes malicious onslaughts against medical practitioners. Past experience teaches that in the event of another period of economic recession it must be anticipated that the number of claims will greatly increase.

No physician is immune to a malpractice suit. Obviously a physician cannot be unjustly accused of malpractice if he cares for every patient with painstaking attention to the requirements of good practice. However, the exercise of even the highest degree of skill and care will not ward off the unjust claim. A point has been reached at which any physician is unwise who does not routinely take all the available precautions to safeguard himself against the unjust accusation of malpractice.

DUE OR ORDINARY CARE

The law requires that every person act with due or ordinary care toward his fellows. Failure so to act constitutes negligence. Due or ordinary care means the degree of care commonly possessed and exercised by the ordinarily prudent person in the conduct of all his activities. A standard is thus established which all must meet. Anyone in everyday activity may be adjudged negligent if an injury to another person or another's property results from failure to do something that the average person would do or from doing something that the average person would refrain from doing in the same circumstances.

There is a legal standard, too, which the professional man must meet in carrying out his professional activities. The standard is always what the ordinary, reputable practitioner, in the same field of practice, in the same or in a similar locality, would do and what he would refain from doing in a similar case.

The failure of a medical practitioner to meet the standard of practice, with injury resulting to his patient, constitutes professional negligence. Professional negligence is called malpractice by the courts.

PHYSICIAN-PATIENT RELATIONSHIP

An analysis of physician-patient cases reveals that the courts almost uniformly hold that a physician is bound (1) to use reasonable care, attention and diligence in the performance of his professional services; (2) to act according to his best judgment in treating his patients, and (3) to possess and exercise the degree of skill and of learning which is ordinarily possessed and exercised by members of his profession in the same or in a similar locality. Failure to perform his duty in these respects is regarded as malpractice. But if the physician has fully complied with his duty and has exercised the requisite degree of care and skill, he is not ordinarily held liable for mere error of judgment (if there is any) in the selection of the course of treatment to be followed. The physician is justified in his selection of a method of treatment if it is one that would be approved by even a respectable minority of his reputable colleagues in the locality. However, he cannot excuse himself on the theory of mere error of judgment if he fails to inform himself of facts by a proper examination of the patient.

One who holds himself out as a specialist and who claims to be expert in a particular field of practice is held to a higher degree of care and skill than is an ordinary practitioner. He must possess and exercise the degree of care and skill commonly possessed and exercised by the specialist in the particular field of practice.

Unless he so expressly agrees and undertakes, a physician is not held to be an insurer or warranter of the results of his treatment. A good result is not impliedly guaranteed. Nonsuccess or unsatisfactory results will not alone establish the elements of legal detriment. This point is well illustrated in a case[1] in which the court said that a physician cannot be held responsible for the failure of the patient to respond satisfactorily to treatment or to make rapid progress toward recovery if the physician used a treat-

ment which was recognized and customary in the medical profession and if he employed reasonable skill and diligence.

The patient must always authorize or consent to the treatment which is administered. Above all, there must be consent to operation. Oral consent is valid, but, obviously, proof of consent is easier when the authorization is in written form. With reference to consent, a New York court in a controlling case[2] said that every human being of adult years and sound mind has a right to determine what shall be done with his own body and that a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.

CASE OF STERILITY

In an operation on husband or wife the consent of the one being operated on is sufficient.[3] However, in an operation on either husband or wife which is likely to result in sterility, it is desirable to secure the written consent of both the husband and the wife. It should be borne in mind, too, that it is hazardous to sterilize any person except on a positive medical examination.

In cases in which an operation is made compulsory by law (such as vaccination or sterilization[4]) the law furnishes the consent. If an operation is unlawful, consent to the performance thereof does not absolve the surgeon from liability.

The consent of a person non compos mentis is no consent at law. The consent of the one who stands in the position of guardian to such a person is required for performance of an operation. If the patient is a minor, consent to operation must be obtained from the parents or guardian.

In an emergency which justifies immediate action for the preservation of the life or health of a patient, and in which it is not practicable to obtain his consent or the consent of any one authorized to speak for him, it is the duty of the attending physician to perform such operation as good surgical practice demands without such consent.[5]

In the absence of evidence to the contrary there is a presumption that a physician has performed the duty undertaken by him with reasonable care and skill. Negligence or want of skill must be affirmatively proved. The rule is well established that a physician cannot be held liable for the death of a patient under his treatment where there is no evidence to show negligence or lack of skill on his part to overcome the *prima facie* case in his favor. In any case, however, when the plaintiff proves by a preponderance of all of the evidence that he suffered injury because the physician failed to act in accordance with the standard of practice in the community, he may recover a judgment for monetary damages against the physician.

In the ordinary case legal proof of malpractice requires that some physician testify on behalf of the patient. This requirement is readily understandable, for only a physician is competent to say what is or is not good practice, either in the diagnosis or treatment. A lay person may state what was done, but only a physician can testify as to the propriety of the things done. Ordinarily, then, a malpractice action will fail unless some physician comes into court and gives testimony which, in effect, condemns the defendant physician's conduct of the case.

Expert testimony is unnecessary in actions based on allegation of operation without consent, invasion of the right of privacy or breach of warranty to cure or to effect a certain result. In matters which are within the common knowledge and understanding of laymen, expert testimony is not necessary. Further, whenever a practitioner acknowledges fault or negligence, by his own statement or admission, expert testimony may not be required.

EXTRACTS FROM MALPRACTICE CASES

Extracts from a few cases will illustrate the foregoing comments:

1. In a North Dakota case[6] the court said that, as a general rule, it is improper to submit a malpractice case to a jury without expert testimony to establish the standard according to which the jury is to judge the conduct of the defendant.

2. In a California case[7] the court said that standards of practice of physicians in a community can be established only by the testimony of experts.

3. In an Iowa case[8] the court said that the testimony of laymen or nonexperts cannot determine whether or not a physician exercises the degree of care and skill required of him in the treatment of a particular patient, for only those learned in the profession can say what should have been done or that what was done ought not to have been done.

4. In a Nebraska case[9] it was held that when a case demands the employment of scientific technic of which a layman can have no knowledge, a charge of negligence must be proved by expert witnesses.

5. In a Kentucky case[10] the court said that the right of recovery in a malpractice action can be established only by the testimony of experts unless the evidence shows an act or an omission within the common knowledge and understanding of laymen.

6. In an Indiana case[11] it was held that when the patient proves that an incision was closed over a laparotomy sponge used in an abdominal operation, expert testimony concerning negligence of the operating surgeon is unnecessary.

7. In a Kansas case[12] it was held that negligence in not setting or treating a badly dislocated elbow need not be established by a medical witness, since it is a matter of common knowledge that such an injury needs treatment.

8. In a California case[13] it was said that it is common knowledge that the removal of the uvula and of a portion of the soft palate is no part of a tonsillectomy.

9. In Illinois[14] a physician was sued as the result of a burn sustained by a patient from an electrotherapeutic machine. The plaintiff's mother had stated to the physician that the plate was loose and that the burn was due to carelessness. The defendant's response to her, "I know it and I can't tell you how bad I feel about it," was admissible as an admission against interest.

10. In a Washington case[15] the court said that the law is well settled that a physician may specially contract to effect a certain result and that he then becomes liable on his contract for failure to fulfill his agreement.

There is no doubt that a physician has a duty to make a sufficiently full disclosure of all of the pertinent facts of a case so that the patient may be in a position to decide, intelligently, whether to submit to any original or subsequent treatment. This conclusion is supported in many cases:

1. In an Oklahoma case[16] the point was made that it is the physician's duty to exercise the highest degree of good faith in dealing with his patients.

2. In a California case[17] the court said that the confidential relationship of physician and patient imposes on the physician the duty of refraining from fraudulent concealment with respect to matters on which he is consulted by the patient.

3. In a number of cases[18] from several states the courts have held that, if the attending physician knows that he cannot accomplish a cure or that the treatment adopted will probably be of no benefit, it is his duty to advise his patient of these facts.

LAW OF NEGLIGENCE

The doctrine of *res ipsa loquitur* is of increasing importance in the law of malpractice. *Res ipsa loquitur* (literally, the thing speaks for itself) is a doctrine of the general law of negligence. It is held applicable whenever one person is injured by an instrumentality entirely in the control of another person, the use of which does not ordinarily result in injury if the person in control exercises due care.

Generally, as has been indicated, the proof of a physician's negligence must be established by the testimony of medical expert witnesses. The application of the doctrine of *res ipsa loquitur* creates in the case an inference of negligence on the part of the defendant, and it relieves the plaintiff of the necessity of proving the alleged malpractice by the testimony of experts. It places on the defendant the burden of making explanation, if he can, to offset the inference of negligence; and by the majority rule a question is created for the jury, regardless of any and all evidence presented by the defendant.

The doctrine of *res ipsa loquitur* has been held applicable in the field of malpractice chiefly in cases which involve (1) slipping instruments, (2) sponges left in the tissues, (3) burns from heating modalites, (4) roentgen radiation injuries (generally limited to cases wherein the roentgen ray is being used diagnostically), (5) infection through the use of an unsterilized needle or instrument and (6) injury to a portion of an anesthetized person's body outside the field of treatment or operation.

CASES CITED

The doctrine of *res ipsa loquitur* has been held applicable in cases such as those which follow:

1. In a Minnesota case[19] a patient's tongue was cut by an electrically driven instrument.

2. In a Washington case[20] the court held that a surgeon is negligent as a matter of law when, in performing an operation, he leaves a sponge in the wound and there is no possibility of any good resulting therefrom.

3. In a New Jersey case[21] the court said that, notwithstanding the nurse's count, a duty remained with the defendant to examine independently, to make sure that no foreign body remained in the patient's body.

4. In a Montana case[22] the surgeon was employed to remove a fibroid tumor and the appendix, and the patient sustained a burn on the chest while anesthetized.

5. In cases from many states[23] negligence was assumed when injury followed diagnostic use of roentgen rays.

On the other hand, the doctrine of *res ipsa loquitur* has been held not to apply in the following cases:

1. In a Minnesota case[24] the court said that the failure on the part of a physician to effect a cure by treatment and operation was not ground for the application of the doctrine, since such failure occurs under the most skillful and careful treatment.

2. In another Minnesota case[25] negligence was not assumed from a claim that death resulted from the injection of an anesthetic agent.

3. In a Washington case[26] the doctrine was held not applicable when the patient's bladder leaked after an operation for the removal of the uterus.

4. In a Minnesota case[27] the doctrine was held inapplicable in action against the surgeon when expert testimony disclosed that a lesion discovered on the patient's thigh after operation could have resulted from a cause or causes other than the alleged burn from a hot water bottle.

5. In an Alabama case[28] it was held that the doctrine does not apply to the mere fact of the occurrence of a blood infection, no matter how closely in time the infection may follow a medical treatment.

TREND WIDENS

There is a threatening and obvious trend toward extending the doctrine of *res ipsa loquitur* to embrace more and more cases. Unless this trend is checked, the occurrence of a bad result will in itself give rise to an inference that the attending physician was negligent. In such a situation, every physician who is foolhardy enough to practice at all will for all practical purposes become an insurer of the results of his treatment.

A physician's liability for negligence or malpractice extends to acts or omissions of his employees, within the scope of the employment. He

is also, of course, liable for the professional acts of a partner. Further, he is liable for the acts of hospital personnel, as far as such acts occur under his direct supervision and control; thus the operating surgeon, and not the hospital, is liable for negligence in the operating room.

Whenever a medical practitioner enters a case in response to a request that he render professional services, he is legally bound to give (or to see that there are given) such services as the case requires until they are no longer needed; he is freed of responsibility only if he is discharged or if he withdraws from the case. This responsibility is illustrated in two typical cases:

In a North Dakota case[29] the court said that part of the physician's correct treatment of a patient is the careful and proper determination of the moment when relation with the patient shall end.

In an Alabama case[30] it was held that when a physician undertakes to treat a patient whose condition he knows to be such that without continuous or frequent attention injurious consequences may result, he must either render such attention himself or see that some other competent person does so.

In all cases sound professional judgment must be exercised to provide, in accordance with the standard of practice, sufficient observation, investigation and treatment.

Whenever the rendition of professional services is followed by a less than perfect end result, a potential malpractice claim exists. When a poor result is accompanied by an unfounded suggestion that faulty treatment was administered, a malpractice claim can almost automatically be expected. This analysis of the situation is not pleasant, but it is realistic. Perhaps little can be done to eliminate poor results; however, it is not only possible but imperative that the factor of unfounded criticism be eliminated.

UNDUE CRITICISM

More than 75 per cent of all malpractice cases are precipitated by some medical practitioner's criticism of the work done or the result obtained by another. Such unethical and destructive criticism obviously must be stopped.

To be sued for malpractice is a miserable experience for any physician. His reputation and his professional integrity are assailed and put in jeopardy. The mere filing of a malpractice action is in itself injurious to him. For example, it is altogether different than being sued for allegedly negligent driving of an automobile. In addition to the mental and emotional stress and loss of time to the physician, the increasing number of unjustified claims is imposing a mounting burden of costs. Furthermore, and no less significant, there is inevitably a lowering of public confidence in the medical professions.

Concrete evidence shows that most of the malpractice claims which are brought against members of the healing professions are not meritoriously founded—that is, the majority of such claims are not honestly and factually justifiable. Moreover, the targets of these actions are not exclusively or generally charlatans or quacks. On the contrary, more than half of all the defendants in these actions are above the median in experience, reputation and ability in their respective fields of practice.

These charges of malpractice have become so common that in certain localities every patient with a less than perfect end result is a potential malpractice claimant. If a physician is intelligently malpractice-conscious, he must and will give thought to safeguarding himself while he is treating a patient, because an unjustifiable claim may eventuate from the case. This unwholesome situation is steadily becoming worse. Obviously, the public interest is seriously and deleteriously affected by it.

PREVENTION OF SUITS

Prevention is the best defense against malpractice. The following briefly outlined measures have been found to be effective and have been recommended, in whole or in part, by all who have given consideration to the problem of malpractice:

1. The physician should care for every patient with scrupulous attention to the requirements of good medical practice.

2. The physician must know his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. "Ideal" medical records should be kept in every case: records that would be presentable when offered in court; records that clearly show what was done and when it was done; records that indicate that nothing was neglected and that the care given fully met the standard demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the record should show it; a good method is to file a carbon copy of the letter which advises the patient against the unwise course.

5. The physician should be careful to avoid making any statement which constitutes or which might be construed as an admission of fault on his part. Such an admission, which is usable against the physician, might be made to a third party as well as to the patient at any time before the trial. Such an admission may be made by an agent or employee of the physician during the course and within the scope of the employment. It is important to instruct employees to make no statements.

6. The physician should exercise tact as well as professional ability in handling his patients. A proper professional manner and a sound attitude should be maintained at all times, both toward the patient and toward the patient's family. The attentive physician may early sense some unsatisfactory and disturbing undercurrent, which may be prevented by the institution of protective measures, from developing into something much more unpleasant. Thus, if the patient is not doing well, consultation may be suggested; if the patient is dissatisfied or complaining, or if the family's attitude indicates dissatisfaction, consultation should be demanded. The use of a consultant affords, in any case, great protection against a malpractice claim.

7. The physician should refrain from over-optimistic prognoses and should avoid promising too much to the patient.

8. The physician should advise his patients of any intended absence from practice and should recommend, or make available, a qualified substitute.

9. The physician should unfailingly secure written consent for operation and for autopsy.

10. There should be careful supervision of assistants and employees and great care in the delegation of duties to them.

11. The physician should have some knowledge of the Statute of Limitations and of its significance.

12. In his selection of patients the physician should limit himself to such fields as are well within his qualifications. He should keep abreast of progress in the medical profession.

13. The physician should keep inviolate all confidential communications.

14. He should frequently check the condition of his equipment and make use of every available safety installation.

15. In the treatment of the patient the physician must not experiment.

16. The physician must be careful to render sufficient care to his patient in general instructions, frequency of visits, clinical and roentgen ray laboratory investigations and the like. Moreover, every precaution should be instituted for the protection of those caring for the patient and of all other contacts.

17. The patient must not be abandoned. The physician-patient relation can be terminated without liability only in certain ways and under certain conditions.

18. The physician should never reveal that he carries professional liability insurance. He should never write a letter or make any statement with reference to a malpractice claim, except on the recommendation of his legal adviser. Immediately on being advised of even the possibility of suit he should consult with his attorney.

19. The physician should arrive at an understanding in the matter of fees. Misunderstanding in this matter, particularly when the question of excessive fees arises, contributes an avoidable element of risk.

20. The physician should secure legal advice if he is called to attend a coroner's inquest as a witness in a case in which he has been in professional attendance.

21. The physician should realize that because of the possibility of error in transmission, it is dangerous to telephone a prescription.

22. The physician should realize that it is hazardous to sterilize any patient, except when a medical indication exists.

23. Except in actual emergency, no female patient should be examined unless a third person is present. There is no more serious or destructive charge in the "malpractice book" than that of undue familiarity; and the only way to avoid claims of this sort seems to be to have some one else present during all examinations.

CONCLUSION

Those who have realistically viewed the problem have realized that there is no malpractice Santa Claus, that the problem will be solved only by the affirmative and purposeful action of the professional groups. Physicians must learn what they may do to safeguard themselves and must put into effect every possible precaution against unjust malpractice accusations. The vast majority of malpractice suits can be avoided by scrupulous attention to the requirements of good practice, provided that this attention is accompanied by an equally scrupulous care for the reputation of fellow medical practitioners.

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3. Rytkonen v. Lojacono (Mich.), 257 N. W. 703; Burroughs v. Crichton, 48 App. D. C. 596.
4. Under Eugenic Sterilization Statutes.
5. 48 C. J. 1131; Jackovach v. Yocum (Iowa), 237 N. W. 444.
6. Whitson v. Hillis (N. D.), 215 N. W. 480.
7. McNamara v. Emmons, 36 Calif. App. (2d) 199.
8. Nelson v. Sandell (Iowa), 209 N. W. 440.
9. Winters v. Rance (Neb.), 251 N. W. 167.
10. Stacy v. Williams (Ky.), 69 S. W. (2nd) 697.
11. Funk v. Bonham (Ind.), 183 N. E. 312.
12. McMillen v. Foncannon (Ken.), 273 Pac. 237.
13. Thomsen v. Burgeson (Calif.), 79 Pac. (2d) 136.
14. Adamsen v. Magnelia, 280 Ill. App. 418.
15. Brooks v. Herd (Wash.), 237 Pac. 238.
16. Mattingly v. Sisler (Okla.), 175 Pac. (2d) 796.
17. Pashley v. Pacific Electric Co. (Calif.), 153 Pac. (2d) 325.
18. Tvedt v. Haugen (N. D.), 294 N. W. 183; Lewis v. Durnell (Maine), 24 Atl. 945; Logan v. Field, 75 Mo. App. 594; Benson v. Dean, 232 N. Y. 52; Mernin v. Cory (Calif.), 79 Pac. 174.
19. Ellering v. Gross (Minn.), 248 N. W. 330.
20. McCormick v. Jones (Wash.), 278 Pac. 181.
21. Stawicki v. Kelley (N. J.), 174 Atl. 896.
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23. Lewis v. Casenburg (Tenn.), 7 S. W. (2d), 808; Shockley v. Tucker (Iowa), 103 N. W. 360; Hamilton v. Harris (Texas), 223 S. W. 533.
24. Johnson v. Colp (Minn.), 300 N. W. 791.
25. Johnson v. Arndt (Minn.), 243 N. W. 67.
26. Brear v. Sweet (Wash.), 284 Pac. 803.
27. Wallstedt v. Swedish Hosp. (Minn.), 19 N. W. (2d) 426.
28. Woodlawn Infirmary, Inc. v. Byers (Ala.), 112 So. 831.
29. Halverson v. Zimmerman (N. D.), 232 N. W. 754.
30. Jackson v. Burton (Ala), 147 So. 414.

High Spots of A.M.A. Session . . .

Membership Dues for 1950 in Amount of $25 Authorized; Action Taken On Measures Pending in Congress; Other Important Business Reviewed

MEETING in conjunction with the Interim Clinical Session of the American Medical Association in Washington, D.C., December 6-9, the House of Delegates transacted the following business:

Approved a recommendation of the Board of Trustees that members of the American Medical Association pay dues of $25.00 for 1950 to be collected through the state medical associations for transmittal to the A.M.A. office at Chicago.

This will be the first time in its history that A.M.A. has charged membership dues. The action was taken in compliance with Article Eleven of the Constitution of the A.M.A. authorizing the levying of annual dues. Those delinquent in payment of the $25.00 membership dues will forfeit their membership in the A.M.A. Those desiring to continue as Fellows of the A. M. A. and receive *The Journal of the A. M. A.* will continue to pay fellowship dues direct to the A.M.A.

FELLOWSHIPS

Since no change was made in the Constitution and By-Laws regarding Fellowship, the eligibility for Fellowship, and Fellowship dues, will remain the same. In other words, to be a Fellow a physician must first be a member in good standing of the A. M. A. (a dues-paying member) and must pay $12.00 per year direct to the A. M. A.

Starting January 1, 1950, a physician who wishes to be a Fellow will pay $25.00 membership dues and $12.00 Fellowship dues, a total of $37.00.

Fellows will continue to receive The Journal of the A. M. A. without additional cost and will be eligible to be on A. M. A. programs and be an officer, delegate or committeeman of the A. M. A.

Members of the A. M. A. will be sent a membership card and membership certificate from the A. M. A. office, as soon as his membership dues are received at that office from the Columbus Office of the Ohio State Medical Association which will be the collection center for A. M. A. membership dues in Ohio. Also, members will be permitted to attend all sessions of the A. M. A. In the past, only Fellows were extended this privilege.

In recommending this action to the House of Delegates, the Reference Committee on Changes in Constitution and By-Laws, to which the matter had been referred for hearings, presented the following statement, enumerating the need for A.M.A. membership dues:

REASONS ENUMERATED

"The responsibilities of the American Medical Association are increasing constantly and the revenues of its publications can no longer meet the costs of its broadening program. The American Medical Association recognizes the greatly augmented activities of the constituent associations and of the component medical societies. However, it is aware of its own responsibility in providing aggressive, effective leadership for the medical profession on a national level. This leadership includes constructive assistance in building and improving the many splendid voluntary health insurance systems, so that all who desire or need prepaid medical care may be provided with it, without political controls or compulsion.

"The American Medical Association, like other great national organizations, must depend on dues from its membership to support its growing program of service, both to the profession and to the public."

PLAN BEING FORMULATED

Details of the collection of the A.M.A. $25.00 dues among members of the Ohio State Medical Association are now being worked out by The Council. As soon as a practical procedure has been set up, notice will be sent to all members and to the Secretary-Treasurers of all County Medical Societies, who will be requested to assist in the collection.

Received a report from the Board of Trustees that Dr. Morris Fishbein had retired as editor of *The Journal of the A. M. A.* and that the editorship has been filled by Dr. Austin E. Smith, who has been secretary of the Council on Pharmacy and Chemistry.

It is understood that Dr. Fishbein has accepted a position as medical consultant to Doubleday & Company, publishers, and that he also will be contributing editor of *Postgraduate Medicine*, official journal of the Interstate Postgraduate Medical Association. Editorship of the nine special journals published by the A.M.A. has been taken over by Dr. Richard J. Plunkett. Dr. W. W. Bauer, long-time director of the Bureau of Health Education, will be in charge of the

publication of *Hygeia*, the name of which is being changed to *Today's Health.*

Registered opposition to S. 1453 and S. 1411, now pending in the Congress, in their present forms. The former is the so-called Federal aid to medical education proposal and was objected to on the ground that in its present form it would give too much power to the Federal Government in the running of medical schools. S. 1411 is the so-called Federal School Health Services measure. It was disapproved in its present form because it would permit the funds to be used to provide medical services for any child regardless of the financial status of the parents.

COMMITTEE NAMED

Authorized the appointment of a special committee of five to confer with the American Hospital Association, the Veterans Administration and various veterans' organizations on the matter of establishing a program whereby veterans with non-service connected disabilities who are eligible for medical and hospital care at government expense would be provided with medical and hospital insurance coverage under which such veteran could receive medical and hospital services from physicians and hospitals of their own choice.

The House of Delegates at its June, 1949, meeting did not endorse a proposal of this kind but referred the matter to the Board of Trustees. The same proposal was introduced at the Washington, D.C., session. Again, the House of Delegates refused to endorse the resolution, pending further study by the committee of five which will be appointed by the Speaker.

HEALTH OFFICERS' SALARIES

Went on record as advocating that the salaries of full-time public health officials shall be "commensurate with duties and responsibilities" of their offices In effect, this endorsed higher salaries for most full-time public health officials.

Received notice from the Board of Trustees that A.M.A. representatives will be sent to England to study the British National Health Insurance Program.

Adopted resolutions urging the National Security Resources Board to work out plans immediately for an adequate civil defense program and advocating the standardization of equipment used in the procurement and dispensing of blood and more cooperation between all agencies engaged in blood procurement programs.

Approved the appointment of Dr. Herbert B. Wright, Cleveland, as a member of the Council on National Emergency Medical Service, to succeed Dr. W. M. Craig, Rochester, Minn. Dr. Wright is president of the Cleveland Academy of Medicine, member of the Committee on Public Relations and Economics of the Ohio State Medical Association, and an alternate delegate from Ohio to the A.M.A.

Elected Dr. Andy Hall, Mt. Vernon, Ill., the "General Practitioner of the Year" and awarded him the Association's gold medal.

EDUCATION CAMPAIGN

Heard a report from the National Education Campaign Committee showing that action against compulsory health insurance has been taken by 1,829 national, state, and local organizations as a result of the program of public relations. The report revealed that during the first 11 months of 1949 $2,250,000 in assessments was paid to the American Medical Association.

Of the $2,250,000, $2,050,000 was budgeted and approved for campaign purposes, leaving $200,000 unbudgeted. Expenditures included $1,045,614 for campaign literature and printed materials; $139,415 for organization work and $209,122 operational expense.

Of the entire campaign budget, expenditures for literature and campaign materials totaled 75 per cent; organization work, 10 per cent; operational expenses, 15 per cent. More than 55,000,000 pieces of campaign literature were produced and distributed.

A copy of the report will be mailed by Whitaker and Baxter, national directors of the campaign, to every physician in the country.

Drs. Schriver, Sherburne, Wiseley, Lincke, Woodhouse, Skipp, Brindley and Wright, representing the Ohio State Medical Association, took an active part in the session. Dr. Paul A. Davis served as a delegate, representing the Section on General Practice. Ohio was represented on the Reference Committee on Credentials by Dr. Lincke; on the Reference Committee on Sections and Section Work by Dr. Davis; on the Reference Committee on Rules and Order of Business by Dr. Sherburne; on the Reference Committee on Hygiene and Public Health by Dr. Wiseley.

Reserve Gets Heart Grants

A total of $358,109 in Public Health Service grants to support heart research and to build additional heart research laboratory facilities in universities, hospitals, and other institutions throughout the country was announced.

The grants include $33,976 to Western Reserve University for experimental investigations to improve the circulation of the coronary arteries by Dr. Claude S. Beck, and $3,780 to the same university for experimental production of arterial disease conducted by Dr. J. Lowell Orbison.

The International and Fourth American Congress on Obstetrics and Gynecology will be held at the Hotel Statler, New York City, May 14-19. Additional information may be obtained from Dr. Fred L. Adair, 161 E. Erie St., Chicago 11, Ill.

Prescribing Barbiturates . . .

State Board of Pharmacy Offers Some Interpretations on the New Law As It Pertains to the Procedure of Filling Physicians' Prescriptions

THE State Board of Pharmacy, in session in Cincinnati on November 16, gave its interpretation of 12 questions submitted to it as applying to the State Barbiturate Act. Since the questions all have to do with the filling of prescriptions, they will be of interest to physicians as well as pharmacists.

House Bill 308, to regulate the handling, sale, and distribution of barbiturates in Ohio, became law on August 12, 1949. Its provisions were given in the July issue of *The Journal.*

The Pharmacy Board explains that the answers are the opinion of the board and should not be construed as a regulation promulgated in accordance with the provisions of the Administrative Procedure Act.

The 12 questions and the answers given by the board are as follows:

Question—May a barbiturate prescription marked only by the prescriber's order to refill, be refilled more than once in absence of any designated number of times.? **Answer—One time only.**

Q.—May a prescriber telephone an order to refill a prescription which he had not previously marked to be refilled, without being required to follow it up with a written prescription (a new original)? **Ans.—No.**

Q.—May a prescription issued, filled and filed prior to August 12, which had been written by a practitioner and designated refillable for a definite number of times (the time period for which has not yet expired) be refilled until time period specified has expired? **Ans.—No.**

Q.—May such a prescription, which has been telephoned to a pharmacist, and not manually signed by the practitioner, be so refilled, or will a new original be required? **Ans.—New one required.**

Q.—May a prescription written and issued by a practitioner and filed by a pharmacist prior to August 12, and which has been designated by the practitioner to be refilled "ad lib," "ad inf," "pro re nata," (or abbreviations to the same effect) be refilled upon demand by the patient; or will a new original be required? **Ans.—New prescription required.**

Q.—May a currently written prescription (with specific directions) designated refillable P.R.N. be refilled for an unlimited number of times? **Ans.—Yes. However, we think the pharmacist should ascertain, after a reasonable period, whether the physician still wishes the medication continued under the original directions for use.**

Q.—Will it be lawful for a pharmacist on receiving a telephoned prescription to make a copy in duplicate, send the original to the practitioner for his signature, keep the duplicate on file to be discarded and replaced by the signed original when returned by the practitioner? **Ans.—Yes.**

Q.—Will it be lawful for a practitioner to supply in advance, or for the pharmacist to use, a previously signed prescription blank for the purpose of providing an "ersatz" original for the pharmacist's file? **Ans.—No.**

Q.—Will a pharmacist be required by law to obtain written confirmation or a prescription, previously telephoned to him by a practitioner; or to have such written confirmation on file? **Ans.—First part is No. Second part—it is the practitioner's responsibility to furnish same within 72 hours.**

Q.—Will the failure to receive within 72 hours a written copy from the practitioner invalidate the pharmacist's copy of a prescription previously telephoned by the practitioner and filed according to law? **Ans.—No.**

Q.—Will the absence of such confirmation on the pharmacist's file affect the legality of the patient's possession of drug supplied on the practitioner's telephoned prescription? **Ans.—No.**

Q.—Will the practitioner who fails to deliver to the pharmacist WITHIN 72 HOURS a written prescription IN CONFIRMATION of a telephonic prescription, be subject to penalty? **Ans.—Yes.**

Research Grants

Public Health Service grants totaling $835,770 for medical and allied research projects at non-Federal institutions were announced. A total of 105 projects will be supported at 61 institutions.

Among projects were the following in Ohio, all at Ohio State University: Clark R. Case, $500, for studies in surgical nutrition via jejunostomy feeding; A. S. Fox and Q. Van Winkle, $8,100 for immunogenetic studies of Drosophila melanogaster; and William G. Myers, $14,875 for use of radioisotopes to trace organic compounds of biological significance.

Fees and Public Relations . . .

Committee in California Tackles Delicate Problems Arising Between Doctors and Patients and Comes Out With Some Practical Solutions

THE following article is reprinted from *The Bulletin of the San Diego (California) County Medical Society.* It was written by Dr. Ralph B. Mullenix, chairman of the professional conduct committee of the Society.

It has been reproduced by *The Journal* because it poses, discusses, and offers solutions for one of the most serious problems arising from the physician-patient relationship.

As the title intimates, public relations on the part of the medical profession begins the minute a physician accepts a patient. Whether the relationship will turn out to be good or bad depends primarily on three factors: (1) The quality of the service rendered by the physician; (2) the diplomacy of the physician in dealing with the patient, including the question of charges; and (3) the degree of cooperation shown by the patient. If these factors are present, the average physician will have little difficulty with the average patient in the average case.

* * *

I. INTRODUCTION

The amicable settlement of fee disputes has become the chief responsibility of the Professional Conduct Committee, and the Committee feels it is ready and the time is right for it to publish to the Society the conclusions it has reached during recent years of such activity.

In most instances the protested charges have been fair and reasonable but, sometimes through misunderstanding, the patient believes he has been overcharged. Whatever the basis or justification of the dispute may be, the fact remains it is a dispute and never ends with the single patient involved but, as it becomes broadcast and as similar instances multiply, it develops into a truly significant public relations problem, detrimentally affecting all members of the profession.

Possibly complete solution of this problem will not come until the matter is taken out of our hands by governmental machinery and the longer we remain indifferent to questions such as this the sooner will state or Federal agencies step in to handle our business affairs.

II. CLASSIFICATION OF FEE DISPUTES

Fee disputes fall into one or more of the following categories:

A. The financially irresponsible patient demands the best of care but does not wish or intend to pay for it regardless of his ability to pay.

B. The patient is willing to pay, but his bill, however fair it may be, far exceeds his original estimate.

C. The patient believes that similar service could have been obtained elsewhere at lower cost.

D. Uninformed or ignorant people who have been fairly charged but, having no knowledge of fees or the cost of providing medical service, believe they have been overcharged.

E. Average fees may be entirely out of reach for some scrupulously conscientious patients in the lowest income brackets.

F. Personality clashes and incompatibilities have developed between patient and physician, and refusal to pay the bill is seized as a retaliatory weapon by the aggrieved patient.

G. The patient objects to paying for an examination that failed to produce a diagnosis or for treatment which did not effect a cure.

H. In a few instances patients have been inexcusably overcharged.

III. THE REMEDY

A. **Discussion of Fees**—Discussion of fees prior to rendering a proposed service will reduce disputes to a minimum. A patient who knows what the service is going to cost will have had the opportunity to:

1. Protest the fee.
2. Defer treatment and make inquiry elsewhere.
3. Explain his financial status and perhaps request and receive a reduction.
4. Arrange with the doctor a plan of periodic partial payments if necessary.
5. Terminate his relation with the doctor and seek service elsewhere.

Many physicians naturally object to opening the discussion of fees with potential patients for fear of appearing too much interested in financial reward, or of losing the patient to a less expensive competitor. It is quite certain that we will offend an occasional patient if we all adopt this practice of fee discussion. Every office will develop its technique of handling this delicate problem, but handle it we must. Whether the matter be broached bluntly by the physician, or even by the receptionist prior to the first consultation, or whether the physician can tactfully turn the conversation so that the patient will himself open the discussion, will depend on the wishes of the individual doctor. The time-

worn practice of evading the patient who has plainly asked for an estimate of charges is mentioned only to be condemned.

Agreement having been reached prior to performance of a service, the patient will usually realize that he has no basis for later protest of the fee. Referring back to the main categories of fee disputes listed above, it is seen that we have dealt effectively with the chief offenders, categories A, B, C, D, and E. These include (1) the financial deadbeat, (2) the patient who just didn't think it would cost that much, (3) the one who thinks he could have gotten it more cheaply elsewhere, (4) the uninformed and ignorant who have no knowledge of average or proper fees, and (5) the conscientious patient who simply cannot afford average standard fees.

B. **Publication (to physicians) of average fee schedule**—Such a schedule would indicate average charges for a certain locality. It should and would serve as a guide for the doctor who seriously attempts to make proper charges and would protect him from stepping too far out of line to his later detriment. It has long been the right of a physician to evaluate his own services and for this reason rigid adherence to a fee schedule probably should not be demanded and probably could not be enforced. It should serve as a balance wheel for the entire local profession. Such a schedule is now in preparation in San Diego County.

C. **Thoughtful explanation of the patient's problem**—Many patients have been disturbed and angered by alleged brevity, impatience, brusqueness, and even crudeness in their brief contacts with their physician. The willingness to explain patiently the problems of diagnosis and treatment, carefully avoiding frank or implied assurances of cure, will almost eliminate the remaining categories of fee disputes. Personality conflicts will then, for the most part, disappear, and the patient will believe he has received what he paid for.

D. **Other measures**—Other measures will include education of physicians to the importance of the problem and, in a few instances, pressure of some sort may be necessary to bring into line the very few who continue to injure the standing of the whole profession by charging excessive fees.

In some localities a "fee complaint bureau" has been established to which the public has been invited to bring their complaints. Our committee feels the establishment of such a bureau would be evidence that we had failed in our attempt to correct our faults by education and persuasion and that such a "bureau" can remain unnecessary and undesirable indefinitely if the basic principles herein proposed are carefully followed by all.

Federal Grants Will Advance Cancer Research in Ohio

Two $300,000 Federal grants for cancer research facilities have been made in Ohio—one at Ohio State University and the other at Western Reserve University.

They are the largest of 14 Public Health Service grants, totaling $2,174,900, made for the construction of cancer research facilities at hospitals, universities and other institutions throughout the Nation.

Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, has been designated to oversee the Columbus program. Dr. Herman A. Hoster, associate director of cancer research at the University, is chairman of the research construction committee, which is planning construction of a laboratory building in the new medical center on the campus.

The new laboratory will bring together under one roof an extensive cancer research program now in operation in small, inadequate laboratories scattered over the campus.

It is significant also that the Ohio General Assembly at its last session made a $100,000 biennium appropriation toward cancer research at Ohio State University.

The other grant of $300,000 was made to Western Reserve University School of Medicine and University Hospitals. Dr. Joseph T. Wearn, dean of the Medical School, and Dr. W. B. Seymour, director of University Hospitals, have been designated to administer the program in Cleveland.

Plans are under way to use the grant for construction of a floor on the new building to be erected at the University Medical Center. The project will relieve crowding of the five cancer research projects now in operation and permit expansion of the university center's cancer research program.

The grants are in the form of outright gifts with no strings attached except that they are designated for construction.

Chronic Illness Commission

Dr. Norton L. Levin, Albany, Department of Health, has been appointed director of the Commission on Chronic Illness. Leonard W. Mayo, New York, is chairman of the commission created last May. It originated under sponsorship of the A. M. A., the American Hospital Association, the American Public Health Association and the American Public Welfare Association.

The National Society for the Prevention of Blindness has announced the appointment of John L. Fortson as director of public relations. He will be in charge of an intensified program of public education on all phases of sight conservation.

On the Firing Line . . .

Shots at Truman-Ewing Compulsory Sickness Insurance Scheme; Ammunition For Doctors in Speeches Against Federalized Medicine

". . . The Supreme Court long ago ruled that there was nothing inconsistent with the due process of law guarantee in the Constitution if the government saw fit 'to regulate that which it subsidizes.' From the beginning of President Roosevelt's New Deal this kind of development has been noticeable. Government aid means government control."—*The Columbus Dispatch.*

* * *

"It is apparent that the Federal government is headed toward an extended era of chronic deficit spending, which may continue until the public debt crushes us into national insolvency."—*Senator Harry F. Byrd (D.-Va.), as quoted by Fletcher Knebel in the Cleveland Plain Dealer.*

* * *

"Many old people have rushed in for 'free' dentures whether they needed them or not. The result is that children whose teeth could have been saved are being neglected."—*Dr. Raymond E. Myers, dean and professor of restorative dentistry, University of Louisville, after a two-month survey of National health program in England and Scotland.*

* * *

"Well over a billion dollars of the cost of the health system is paid out of general taxation. It is one reason why British pay the world's highest income and sales taxes. Indirectly, it is a factor in the high costs which have cut sales of British goods in world markets."—*The late E. T. Leech, Editor, The Pittsburgh Press.*

* * *

". . . Over the head of the farmer hangs a threat perhaps more serious than that applied to the worker. The farmers are paid heavy subsidies to produce more food. But there is a regular inspection of every farm and a record kept of its produce. If the farmer falls short of the kind of job expected of him in following the instructions from London he gets a warning and if he does not mend his ways the government will walk in, put a price upon his property, pay him for it and put him off the farm, which then passes into the hands of a government manager."—*John T. Flynn, The Road Ahead.*

"With the Federal government in the saddle, armed with the mighty weapon of the income tax, two results are almost inevitable: First, the complete subjugation of the States, and second, the socialization of our economy. With relentless precision and frightening speed, the Federal government has seized most of the sources of taxes. The States, defeated at every point, have stultified themselves by accepting handouts in the form of state aid."—*Raymond Moley in the Columbus Dispatch.*

* * *

"Our first line of defense is not on the Rhine. Our first line of defense is a sound, solvent American economy. We cannot keep that economy sound and solvent merely by official statements."—*James F. Byrnes, former Secretary of State in Readers Digest, September, 1949.*

* * *

"The Welfare State is just another version of the old Feudal State . . . it is founded on a lack of faith in people."—*John McPherrin, editor, The American Druggist.*

* * *

"A top Federal Agency official declared today that the administration's proposed national health plan would provide 'all kinds' of medical devices, including wigs, glasses, false teeth, to patients if a doctor ordered them."—*International News Service report in The Columbus Dispatch, quoting John L. Thurston, Federal Security Administration assistant administrator, December 12, 1949.*

* * *

". . . at a time when the Federal government is unable to make both ends meet even with a $40,000,000,000 income, compulsory health insurance alone would pile up to $12,000,000,000 a year more on the sagging backs of the taxpayers!"—*Napoleon Henry County (O.) Signal.*

* * *

"Ewing currently is on a tour of Europe to study state medicine as it has been developed in the Scandinavian countries and in Europe. . . . The tenor of his report can be forecast rather accurately from an interview given the press in London the other day in which he said he was convinced from what he had seen of the British plan that the Truman scheme would be 'good for America'."—*The Columbus Dispatch, December 12, 1949*

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Licensed Through Endorsement By State Medical Board

The Ohio State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians, through endorsement of their licenses to practice in other states:

October 4, 1949—Fred B. Aurin, Cincinnati, Johns Hopkins Univ.; Oscar Baumgarten, Cleveland, Univ. of Basel, Switzerland; Lewis A. Bean, Gallipolis, Univ. of Mich.; Vincent F. Bolton, Uhrichsville, Hahnemann Medical College; Frank A. Brown, Toledo, Meharry Medical College; Herschel L. Browns, Lakewood, Univ. of Mich.; Nathan Cedars, Columbus, Univ. of Rochester; Patrick B. Cestone, Youngstown, St. Louis Univ.; Emma M. W. Clarke, Cleveland, Univ. of Pittsburgh; Wm. T. Collins, Cincinnati, Univ. of Mich.

Theodoro de la Torre, Dayton, Maryland Medical College; Charles R. Frazerk, Jr., Toledo, Meharry Medical College; Victoria S. Friedman, Cleveland, Univ. & Bellevue Hospital Medical College; Robert P. George, Akron, Northwestern Univ.; Louis Z. Gordon, Cincinnati, Wayne Univ.; Izydore Gottlieb, Murray City, Jagiello Univ., Poland; Max Devillo, Springfield, Univ. of Kansas.

Wm. McK. Jefferies, Mayfield Heights, Univ. of Virginia; Wm. R. Johnson, Cleveland, Yale Univ.; Paxton L. Jones, Youngstown, Duke Univ.; John K. Leach, Canton, Albany Med. College; Avard C. Long, Cleveland, McGill Univ.; Walter Lowenstein, Columbus, Univ. of Leipzig, Germany; Daniel W. Mathias, Akron, Western Reserve Univ.; George D. McAfee, Cincinnati, George Washington Univ.; Robert D. Mercer, Cleveland, Univ. of Mich.; George L. Morris, Jr., Hillsboro, Temple Univ.

Thomas R. Nolan, Cleveland, St. Louis Univ.; Joseph P. Ohlmacher, Sandusky, Rush Medical College; Daryl McC. Parker, Hollansburg, Northwestern Univ.; Walter Pavluk, Parma, George Washington Univ.; Edward L. Ringer, Bryan, Univ. of Pittsburgh; Elmer R. Swanson, Middleburgh Heights, Univ. of Pittsburgh; Anthony M. Tanno, Cleveland, St. Louis Univ.; Joseph E. Tomayko, Youngstown, Georgetown Univ.

Rupert B. Turnbull, Jr., Cleveland, McGill Univ.; Keith E. Weller, Delaware, Univ. of Mich.; Frederic B. Western, Apple Creek, Univ. of Ill.; Roger D. Williams, Columbus, Duke Univ.; Herbert L. Wormhoudt, Cincinnati, State Univ. of Iowa.

Professional examinations for the selection of candidates for appointment to the grade of lieutenant (junior grade) in the Medical Corps of the Navy will be conducted at all naval hospitals in continental United States during the period January 16-20. Mid-western candidates will be examined at the U. S. Naval Hospital, Great Lakes, Illinois.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since November 1, 1949. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

BUTLER COUNTY
- Arnold Gross, Hamilton
- Jack I. Smith, Ross (Venice)

CUYAHOGA COUNTY
- Donald T. Book,, Cleveland
- Carl N. Brudzynski, Garfield Heights
- Hatcher A. Day, Cleveland
- Victor G. DeWolfe, Cleveland
- Russell P. Dreyer, Cleveland
- Barbara O. Remetey, Cleveland
- Joseph M. Ryan, Cleveland
- Alan E. Smith, Cleveland
- Robert S. Stockton, Cleveland
- John L. Toth, Jr., Cleveland
- Theodore J. Werb, Cleveland
- Joseph C. Wiggins, Cleveland

DARKE COUNTY
- Richard A. Welsh, North Star

GUERNSEY COUNTY
- Robert D. Crouch, Cambridge

HAMILTON COUNTY
- George D. McAfee, Cincinnati

LORAIN COUNTY
- William F. Lord, Elyria

SCIOTO COUNTY
- Carl H. Laestar, Portsmouth
- Ralph W. Lewis, Portsmouth
- Spencer K. Miller, Scioto-ville

SENECA COUNTY
- Quentin B. Smith, Tiffin

STARK COUNTY
- John J. Douglas, Canton
- Charles L. Kagay, Canton

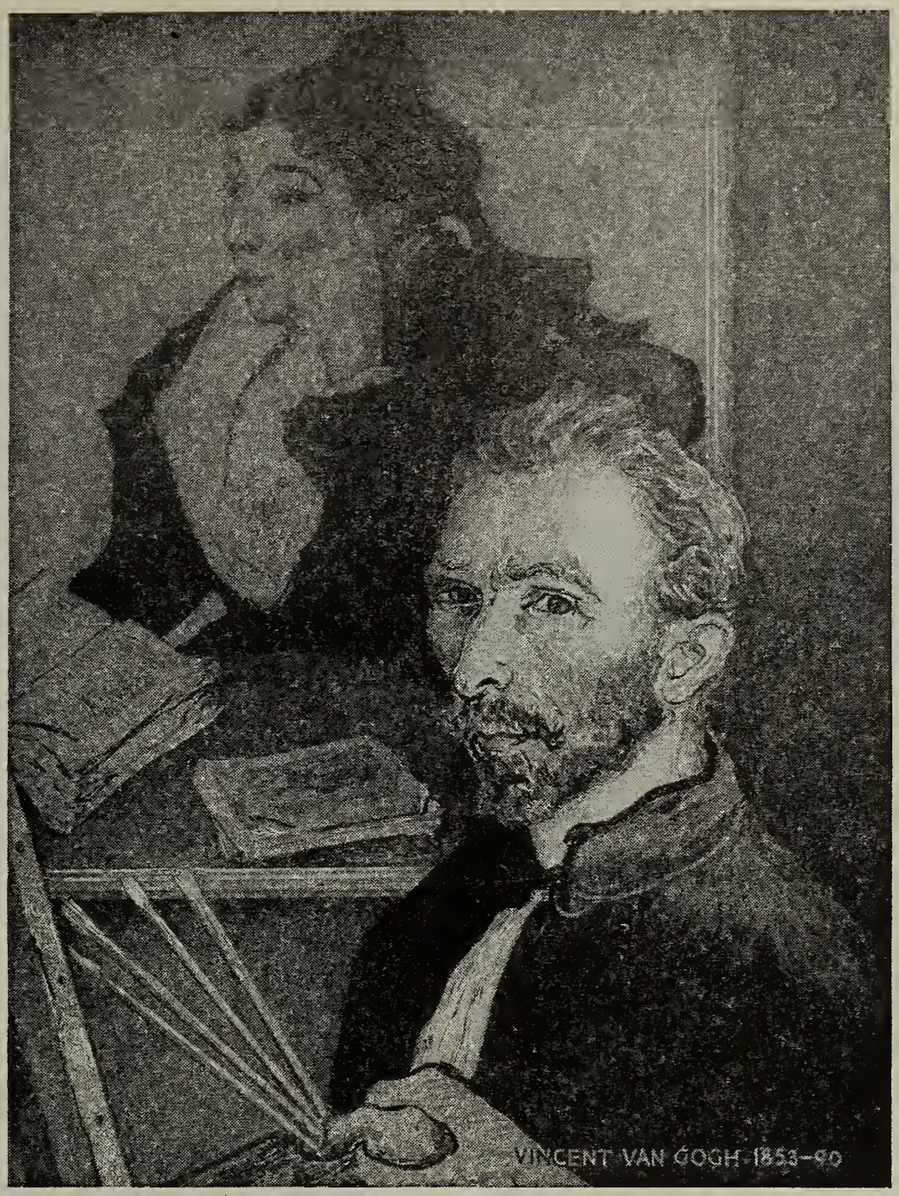
Meiling Will Guide Policies of Consolidated Military Journals

Dr. Richard L. Meiling, of Columbus, recently appointed director of medical services for the Military Establishment, will establish general policies for the guidance of the consolidated professional medical publications of the armed forces, Secretary of Defense Louis Johnson has announced.

The *U. S. Armed Forces Medical Journal*, *Medical Technicians Bulletin of the U. S. Armed Forces*, will replace the *Bulletin of the U. S. Army Medical Department* and the *U. S. Naval Medical Bulletin*. The Air Force, whose separate medical department was created last July, has not had a similar journal. The new publication will begin with the January issue and will be issued monthly.

The *Medical Technicians Bulletin of the U. S. Armed Forces* will be a supplement of the medical journal and will be published bimonthly.

Women practitioners net an average annual income of $7,929 (male doctors average $11,036). They devote nine hours a day to their medical practice (one hour less than men), spend an equivalent of 41 days a year in postgraduate study (eight days more than men). They allow 25 days a year for vacations (to men's 16 days). Only 12 per cent are in full specialty practice (as against 31 per cent of men).—*Medical Economics.*



★ *Epileptic Men of Genius* ★

The Dutch painter, Vincent Van Gogh, one of the masters of Post-Impressionism, suffered from the psychic equivalent type of epilepsy. During one of his many periods of confusion he cut off one of his ears and presented it to a lady friend.

Comparative studies have shown that in some cases better control of grand mal as well as petit mal seizures can be obtained with Mebaral than with corresponding doses of other antiepileptic drugs. Mebaral produces tranquillity with little or no drowsiness. It is particularly desirable not only in epilepsy but also in the management of anxiety states and other neuroses. The fact that Mebaral is almost tasteless simplifies its administration to children. Average dose for children ½ to 3 grains, adults 3 to 6 grains daily. Tablets ½, 1½ and 3 grains.

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

FEW HAVE BEEN ABLE TO ESCAPE THE TAX COLLECTOR

Since the time for filing income tax returns and the payment of income taxes is approaching, physicians would be wise to read carefully the article published in the December issue of *The Journal*, pages 1197-1202, unless they have already done so.

Why physicians should be extremely careful and accurate in making returns was emphasized in an earlier article—pages 1098-1099 of the November issue.

Whether they like it or not, physicians and other self-employed persons who do not pay taxes through a payroll deduction method are given special attention by income tax inspectors.

Persons who have to pay taxes may not like it and if they think taxes are too high or unreasonable they have a right to try to remedy the situation through the ballot box. On the other hand, so long as tax laws are the laws of the land, each citizen is legally and morally obligated to comply with them. If he doesn't, he runs the chance of getting nipped. If he gets nipped, he must accept the blame. Publicity on convictions for tax evasions is harmful to the individual and to his particular business or professional group.

No one has found a way as yet to escape the Grim Reaper at some time along the way. Few have been successful in escaping the tax collector, although some have tried it to their sorrow.

AN INVESTMENT WHICH IS SOUND AND WARRANTED

Those who are carrying on a hate campaign against the A. M. A. have raised their hands in holy horror at the announcement that for the first time in its existence of more than 100 years, the A. M. A. has decided to charge membership dues.

Some of the criticism comes from labor brass and braid which has caused a good laugh among those who know what labor organizations charge for the privilege of being a member.

Others who criticize the charging of membership dues should know better. How many organizations exempt their members from paying something for the privilege of belonging and for the opportunity to receive services from the organization? Because of the many and varied services which it performs for the benefit of its members and the public, the A. M. A. does not have to make an apology for charging membership dues—which it should have been doing long ago.

Any member has a perfect right to disagree with some policy which his local, state or national medical society may have on some specific issue. On the other hand, the society can't be wrong on every issue. It should get credit for some achievements. For that reason, the member should be expected to make a contribution for the right to share in the good things and for the right and opportunity to try to have the policy with which he disagrees, modified, if the policy happens to differ from his own views on the matter.

If the medical profession lets the flanking attack which the welfare state bosses have launched, using the membership dues question as a base, split its ranks and muddle its thinking, it's a dead duck. Aside from its activities in the field of legislation, the A. M. A. performs so many beneficial services for members and citizens alike that a contribution in the form of membership dues can be regarded as a sound investment in anybody's book, even though it may not please everybody all the time.

INSPECTION OF HOSPITALS FOR CASUALTY HAZARDS

A nation-wide voluntary inspection of all hospitals has been inaugurated under the sponsorship of the National Board of Fire Underwriters in cooperation with the American Hospital Association, American Medical Association, the Association of Casualty and Surety Companies and the National Association of Insurance Agents.

Inspection of Ohio hospitals will be under the direction of the Ohio Inspection Bureau, cooperating with the Fire Prevention Association of Ohio and various casualty company associations. Qualified representatives of these organizations will make inspections at hospitals where the management is willing to cooperate.

This program is being carried on as a public service without cost and without any commercial aspects of insurance, the Ohio Inspection Bureau has announced, it being purely in the interest of preventing injuries and loss of life from fire and other perils. Confidential reports on the findings and recommendations for correcting conditions that affect safety to life in the hospital will be transmitted only to each hospital concerned.

It is quite obvious why physicians can, and should, give this project their wholehearted support. Is your hospital going along with this program? Wouldn't it be wise for it to take advantage of this opportunity to have expert advice on how it stacks up and how it can

WHY MANY LEADING NOSE AND THROAT SPECIALISTS SUGGEST

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Where smoking is a factor in a throat condition, the physician may advise "Don't Smoke." But where the patient persists, many eminent specialists suggest *"Change to* PHILIP MORRIS"... the one cigarette proved definitely less irritating.** Perhaps you too will find it advantageous to suggest to your throat patients *"Change to* PHILIP MORRIS." For your own smoking as well, Doctor, in fact for *all* smokers, Philip Morris is by far the wisest choice.



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***Reprints on Request:*

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32,241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

correct conditions which could be dangerous to the life of patients, physicians and hospital employees? Why don't you discuss it in a staff meeting and consider requesting your hospital board to cooperate?

EDITORS ONLY PRINT THE NEWS; THEY DON'T MAKE IT

The House of Delegates of the Ohio State Medical Association in 1948 authorized presentation of a pin and certificate to members and former members who had served 50 or more years in the medical profession.

What started as a sort of "token of appreciation" within the profession has created public interest beyond any possible expectation. The state headquarters, with the cooperation of county societies and doctors throughout the state, has compiled a list of more than 400 of these oldsters in the profession.

The newspapers, to use a colloquialism, have eaten up the stories about these presentations. The Headquarters Office almost daily is receiving clippings from newspapers throughout the state with multiple-column pictures and columns of print devoted to the veteran doctors of their communities, pegged on these presentations.

The newspapers get a lot of unwarranted criticism about playing up the morbid, the bizarre and the sensational. But, like those closely associated with the press know, give them something good to write about and they'll jump at the opportunity.

OFFERS FOR HELP IN CAMPAIGN NEED CAREFUL SCREENING

Every good product has its by-product, some of which may be good and some not so good. We are not surprised, therefore, to hear that the A. M. A. headquarters itself and its National Education Campaign headquarters are being bombarded by agencies with wares or services to sell in connection with the campaign.

Many local societies and individual doctors are being subjected to the same pressure, as queries into the State and National headquarters indicate.

Obviously the national headquarters is not passing up a bet, and is carefully screening and evaluating every offer. The State office in Columbus is doing the same with many requests. Some of the demands are coming from bona fide groups performing excellent work. Some, on the other hand, are merely from agencies or others who are trying to jump on the bandwagon.

As an example of these offers, one firm is offering prepared stickers for doctors to buy directly from them at $25 per thousand. The National headquarters is furnishing doctors (out of campaign funds) a sticker which serves the same purpose at a cost of 80 cents per thousand.

A bulletin from the Chicago office states: "The many demands on physicians and allied professions, for money contributions for purposes supposedly connected with our campaign to preserve the American medical system, are a great drain on individuals and a scattering of shot that should not be wasted."

Obviously neither the medical profession as a group, nor the individual doctor wants to pass up any opportunity to recruit help in our campaign to preserve the American system of medicine. Nor would we antagonize anyone who may honestly feel he is making a contribution to the cause.

On the other hand, individual doctors and local societies should consider carefully each offer to determine that it adds constructively to the campaign and does not duplicate effort.

MEDICAL COVERAGE FOR THE INDIVIDUAL

Discussing health insurance in an editorial, *The Columbus Citizen* recently said:

"Blue Cross and Blue Shield are performing an extraordinary service in this field but vast numbers of people are unable to obtain these policies. What the country needs is a health insurance policy which can be bought over the counter by the individual, just as he buys life, fire and automobile insurance. If the insurance companies can work this out they will be doing the country a great service—and increasing their own profits."

In our opinion, the medical profession will agree with 90 per cent of that statement. It is just as anxious as anyone to see the people blanketed with voluntary prepaid hospital and medical care coverage.

However, this kind of coverage can't be sold exactly as other types of insurance for the reason that the actuarial risk can't be determined quite as definitely. For that reason, care has to be exercised in signing up the "individual" risk in contrast to signing up "groups" where the bad risks are offset to some extent by the good ones.

Also, it is actuarially true that the premium on one person has to be somewhat higher than the premium on persons making up a group. This creates the problem of keeping the cost to the contract holder at a figure which he can afford, or is willing, to pay.

Exponents of wide-open sale of health insurance coverage must keep in mind that no one is going to help the Blue Cross, Blue Shield, or the insurance company meet deficits. They are on their own. They must have the funds available to meet claims. These funds come from the insured. Unlike the government they can't look to general taxation to help them meet their

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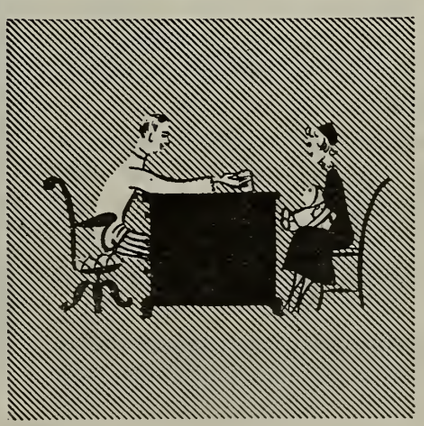
2. SAVES TIME AND MONEY—no milk modifiers needed with Similac; its higher vitamin content must be considered; helps avoid costly complications of ordinary formula feedings.

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bills. To do that would be to ask for, and get, bureaucratic and political control.

Blue Cross and Blue Shield plans are carrying on controlled experiments in individual and community enrollments. Basic facts are being assembled and studied. In our opinion, the whole problem of providing coverage for the individual—the non-group individual—will be met eventually by the voluntary agencies. That's the real solution.

WHO SAYS IT'S NOT A POLITICAL ISSUE?

In a statement to the press, National G. O. P. Chairman Guy G. Gabrielson said the issue on socialized medicine may overshadow the fight on the Taft-Hartley Law during the 1950 election campaigns.

This means, so far as the medical profession is concerned, that physicians are going to have to take more interest than in the past in the activities leading up to the general election in November, 1950. They might as well get set for it now.

The first thing for them to do is to register to vote; see that members of their families are registered to vote; see that friends and acquaintances are registered to vote. The job of analyzing the qualifications of candidates for public office and working for those who measure up, will come when the fireworks start.

PHYSICIANS CAN MAKE OR BREAK THE BLUE CROSS PLANS

The necessity of continuing cooperation between members of the medical profession and Blue Cross is an absolute must if that plan is to achieve its purpose of providing those with limited incomes a means of insuring their families against unpredictable hospital bills.

Hospitals and doctors went into a huddle on the problem of meeting financial losses of that organization at this year's annual meeting of Blue Cross. The question of meeting financial loss by raising fees or limiting benefits was raised. Hospitals and doctors were reluctant to take either step, feeling that it might encourage subscribers to favor the government's so-called "free program."

The Iowa State Medical Association made an analysis to determine the reasons for the high cost of Blue Cross members' hospitalization and came out with some good points, which the local medical advisory of Hospital Care Corporation has handed on.

Results of Iowa's analysis show two sources of possible abuse. One is in hospitalization for diagnostic purposes only, whereas Blue Cross was organized to take care of emergency hospital needs and the services which go with such needs.

The second possible source of abuse lies in the prescribing of costly drugs, laboratory services, oxygen, and physiotherapy, on which there is no limit set in the policy. Some of the charges made to Blue Cross for these services have been staggering.

"The whole plan of hospitalization insurance will be ruined if the present abuse continues," the Iowa report states. "It is felt that the physician must have the moral fortitude to tell his patient he is not entitled to diagnostic services under his contract, and he should remember that, regardless of whether the patient has insurance or not, if his bill is too large, he will be more inclined to look with favor on government insurance.

"Under the Blue Cross Plan, physicians hold the whip hand. They can make or break it . . ."

TAX AND TAX, AND GIVE ORDERS!

Of the forty billion dollars collected by the Federal Government in the fiscal year, 1948, five and one-half billion were returned to the states. Ohio taxpayers paid in $2,665,707,099 and got back $236,982,646, or nine per cent.

All of which indicates several things:

It's costing too much to run the Federal Government.

The states are being gypped.

There should be a reapportionment of taxes, to leave the states and local governments a fairer share of taxes.

Until reapportionment is achieved, the Federal Government is going to continue to tell the states and local units how to run their affairs as they will continue to be dependent on the U. S. for money.

MAYORS OF OTHER CITIES PLEASE NOTE!

The Mayor of Springfield has announced that the city's new board of health, authorized by a city ordinance, will be picked from a list of eligibles submitted by the Clark County Medical Society, according to a story in the *Springfield Daily News.*

His Honor apparently is tackling the question from the right angle. We hope the plan works. Such a deliberative body should be able to come up with some excellent nominees and without political complications. Moreover, such a move is bound to stimulate future interest on the part of the medical profession in the activities of the board.

Mayors of other cities please note!

Buckeye News Notes . . .

Cincinnati—Dr. Edwin Khuon was the subject of a feature article in the *Cincinnati Times-Star*. He has been in practice for 56 years.

Cleveland—Dr. Walter C. Alvarez of Rochester, Minn., spoke before a meeting of the Cleveland Health Museum on the subject, "How To Get Along With Your Nerves."

Columbus—A plaque commemorating James E. Bauman's 57 years with the Ohio Department of Health was presented by fellow workers in the Department. Mr. Bauman retired recently as assistant director, chief of the division of administration and secretary of the Public Health Council.

East Liverpool—Dr. Milton Wolpert addressed the local Kiwanis Club on the subject of popular and scientific use of drugs.

Marietta—Dr. W. S. Hawn was named college physician for Marietta College.

Nelsonville—Dr. Blaine Goldsberry of Athens spoke on "Socialized Medicine" before the Rotary Club.

New Concord—Dr. Walter K. Chess spoke before the local Grange on the subject of Socialized Medicine.

New London—Dr. Courtland B. Meuser of Ashland spoke on the subject of "State Medicine" at a meeting of the New London Rotary Club.

Newark—Three local doctors presented a panel discussion on student health before the St. Francis de Sales P.-T. A. They were Dr. Carl L. Petersilge, Dr. G. A. Gressle and Dr. R. Gilbert Mannino.

Ravenna—Dr. Edgar A. Knowlton of Mantua was named a member of the Portage County Board of Health to fill the seat left vacant by his father, the late Dr. Edgar H. Knowlton.

St. Clairsville—Dr. Homer S. West is retiring as Belmont County Health Commissioner at the age of 70.

Willard—Dr. Harry Wain of Mansfield, Richland County health commissioner, spoke before the local Rotary Club. He discussed the history of preventive medicine leading to modern public health systems and warned against government control of both curative and preventive medicine.

Zanesville—Dr. Paul A. Jones addressed the local Rotary Club as special speaker in a program arranged by Dr. George C. Malley.

Zanesville—Dr. George C. Malley spoke on the subject of the National Compulsory Health Insurance program at a meeting of the St. Thomas Holy Name Society.

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Do You Know? . . .

The Veterans Administration will offer 259 internships to qualified graduates of recognized medical schools in 13 of its hospitals beginning July 1, 1950.

* * *

Dr. Louis H. Bauer, Hempstead, N.Y., Chairman of the Board of Trustees of the American Medical Association, spoke on "Nationalized Medicine" at a meeting of the Columbus Rotary Club, November 21. He was introduced by Dr. C. C. Sherburne, a Past-President of the Ohio State Medical Association and a delegate to the American Medical Association.

* * *

"GP—Published by the American Academy of General Practice", is the official name of the Academy's projected journal. The April, 1950, issue will be Volume 1, Number 1.

* * *

The Geauga County Medical Society, of which Dr. Isa Teed Cramton has been secretary for many years, was the first society in the state to have a 100% record in payment of 1950 State Association dues.

* * *

A school of hospital administration has been established at the Medical College of Virginia, Richmond. The new course will consist of 18 months of training. The course at Virginia is the twelfth such program to be established.

* * *

British Health Minister Aneurin Bevan turned down a bid for higher pay for doctors in the National Health Service. Each doctor now gets a head fee of 18 shillings ($2.52) a patient per year. The profession asked for 30 shillings ($4.20).

* * *

The Bureau of Economic Research and Statistics of the American Dental Association reports that in mid-1949 the United States had a total of 86,904 dentists, an average of one dentist for each 1,727 residents, compared with a dentist-population ratio of one dentist for each 1,817 persons in 1947.

* * *

Dr. Robert S. Dinsmore has been appointed to succeed the late Dr. Thomas E. Jones as chief of staff of surgery at the Cleveland Clinic.

* * *

Dr. Margaret O'Neal, Zanesville, is the new health commissioner of Muskingum County, succeeding Dr. Beatrice T. Hagen, who retired after more than 20 years in that post.

* * *

The Tenth Annual Congress on Industrial Health, sponsored by the Council on Industrial Health of the American Medical Association, will be held in the Roosevelt Hotel, New York City, Feb. 20-21. The sessions will feature discussions on industrial medical service, environmental hygiene and human relations in business and industry. For detailed information write Dr. Carl M. Peterson, Council Secretary, 535 N. Dearborn St., Chicago 10.

* * *

Dr. Richard L. Meiling, Director of Medical Services, Office of the Secretary of Defense, led a discussion on "National Economy, Unification and the Physician", at the annual meeting of the Society of U.S. Medical Consultants in World War II, held in Washington, D.C., November 14.

* * *

New officers of the Ohio Heart Association are: Dr. A. Carlton Ernstene, Cleveland, president; Dr. Wm. H. Bunn, Youngstown, vice-president; Dr. Floyd P. Allen, Cincinnati, secretary-treasurer, and Dr. D. L. Mahanna, Columbus, recording secretary. The Association will be an affiliate of the American Heart Association and will have headquarters in Columbus.

* * *

Dr. Robert Vogel, Sparta, is the new health commissioner of the three-county district of Delaware, Union, and Madison counties. He succeeds Dr. W. S. Ramsey who is now health commissioner of Greenville and Darke county.

* * *

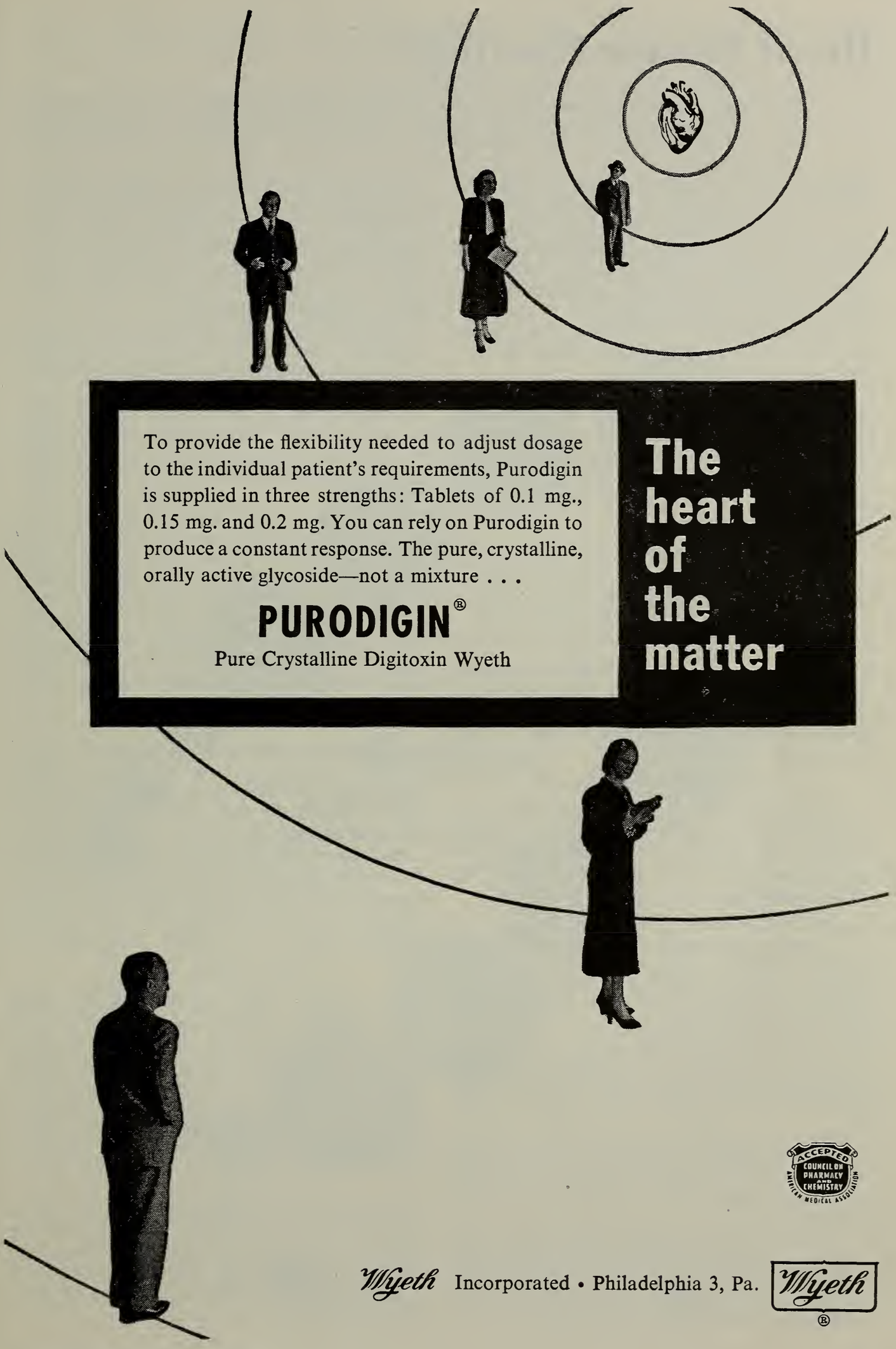
Eleven persons in each 1,000 in Ohio were getting relief aid of one kind or another last June, according to a Congressional survey. Only three states—Rhode Island, Michigan and New York—have a higher percentage of their population on general assistance rolls. The national average was 7.6.

* * *

The University of Kansas School of Medicine now requires 11 weeks of training in rural medicine as a pre-requisite for graduation. Senior students will spend this time as observers in the offices of general practitioners in Kansas towns of under 2,500 population. Thirty-nine preceptors chosen from a list of 200 physicians submitted to the school by the Kansas Medical Society will provide board and room for the students in return for their assistance.

* * *

Dr. Stanley Dorst, dean, University of Cincinnati College of Medicine, is a member of a committee appointed by the Board of Trustees of the American Medical Association, to go to England to make a study of medical education as it now exists under health legislation initiated by the Labor government.


To provide the flexibility needed to adjust dosage to the individual patient's requirements, Purodigin is supplied in three strengths: Tablets of 0.1 mg., 0.15 mg. and 0.2 mg. You can rely on Purodigin to produce a constant response. The pure, crystalline, orally active glycoside—not a mixture . . .
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Rural Doctor Shortage . . .

Ohio Farm Bureau and Ohio Grange Resolutions Express Concern and Urge That Facilities for Education of Medical Students Be Enlarged

THE concern of Ohio's farm organizations about the problem of supplying more doctors for rural areas was demonstrated recently when the delegate bodies of both the Ohio Farm Bureau Federation and the Ohio State Grange approved resolutions on this subject at their respective annual meetings.

Meetting November 28, 29, and 30 in Columbus, the Farm Bureau delegates issued the following statement:

"Since figures show that not enough doctors are being graduated at present to replace the loss of older doctors and since the population is increasing at a rapid rate, we urge that adequate medical facilities for training be provided in order that this acute need for doctors might be met in rural areas.

> **"While we are opposed to Federal socialized medicine, we feel that it might result unless the medical profession itself assumes greater responsibility for providing needed medical services."**

The Grange, which met December 12-15 in Columbus, recommended that "the number of students allowed to prepare themselves for the medical profession be sufficient to care for the rural needs in Ohio."

OPPOSED SOCIALIZED MEDICINE

The resolutions committee of the Ohio Farm Bureau Federation received resolutions from 16 county farm bureau organizations, urging the state organization to go on record against socialized medicine.

The Farm Bureau delegates also:

1. Urged each county to complete a study of health conditions, problems, and facilities, including ways and means of improving local health, and looking toward any enabling legislation that may be necessary.

2. Commended the Ohio Committee on Public Health for the study of state and local health departments and recommended that the Ohio Farm Bureau cooperate with its recommendations.

3. Recommended a voluntary reorganization of public health districts patterned after the recommendations of the Ohio Hospital Survey Committee.

4. Asked that the duties of the health commissioners be made mandatory when they affect important health services, and urged close cooperation of Farm Bureau Home and Community Committees and health commissioners.

5. Approved a resolution recommending that the Federal, State and local health authorities, in cooperation with professional groups, farm organizations, and others, be urged to take every possible legal, legislative and professional action necessary to bring rabies under control and to complete eradication.

6. Insisted that the inspection and licensing of public eating places be under the supervision of the State Department of Health rather than under the State Fire Marshal.

7. Urged that all school personnel, handlers of food in public eating places, and all those who assist in the processing of food be required to have annual health examinations, including chest X-rays.

8. Commended the State Departments of Health and Education for their jointly initiated program of teacher training and certification in health, physical education, recreation and safety; urged that County Farm Bureaus help promote the introduction of health courses into all rural schools; and encourage teachers to attend the extension courses and workshops provided by the State Universities for training in health education.

MISCELLANEOUS RESOLUTIONS

Miscellaneous actions asked that County Farm Bureau Committees cooperate with County Tuberculosis and Health Associations and local health departments in eradicating tuberculosis; that County Farm Bureau home and community committees cooperate with cancer associations in promoting education concerning importance of early diagnosis; and supported the national program for the prevention and cure of social diseases, urging its complete development in Ohio.

OTHER GRANGE ACTION

The Grange, which traditionally acts upon fewer and more general resolutions than does the Farm Bureau, took no other actions concerning health other than the one above on medical training, and another, on restaurant inspection. The latter inferred that sanitary inspection should be a responsibility of the State Department of Health, rather than the State Fire Marshal, who should inspect for fire hazards only.

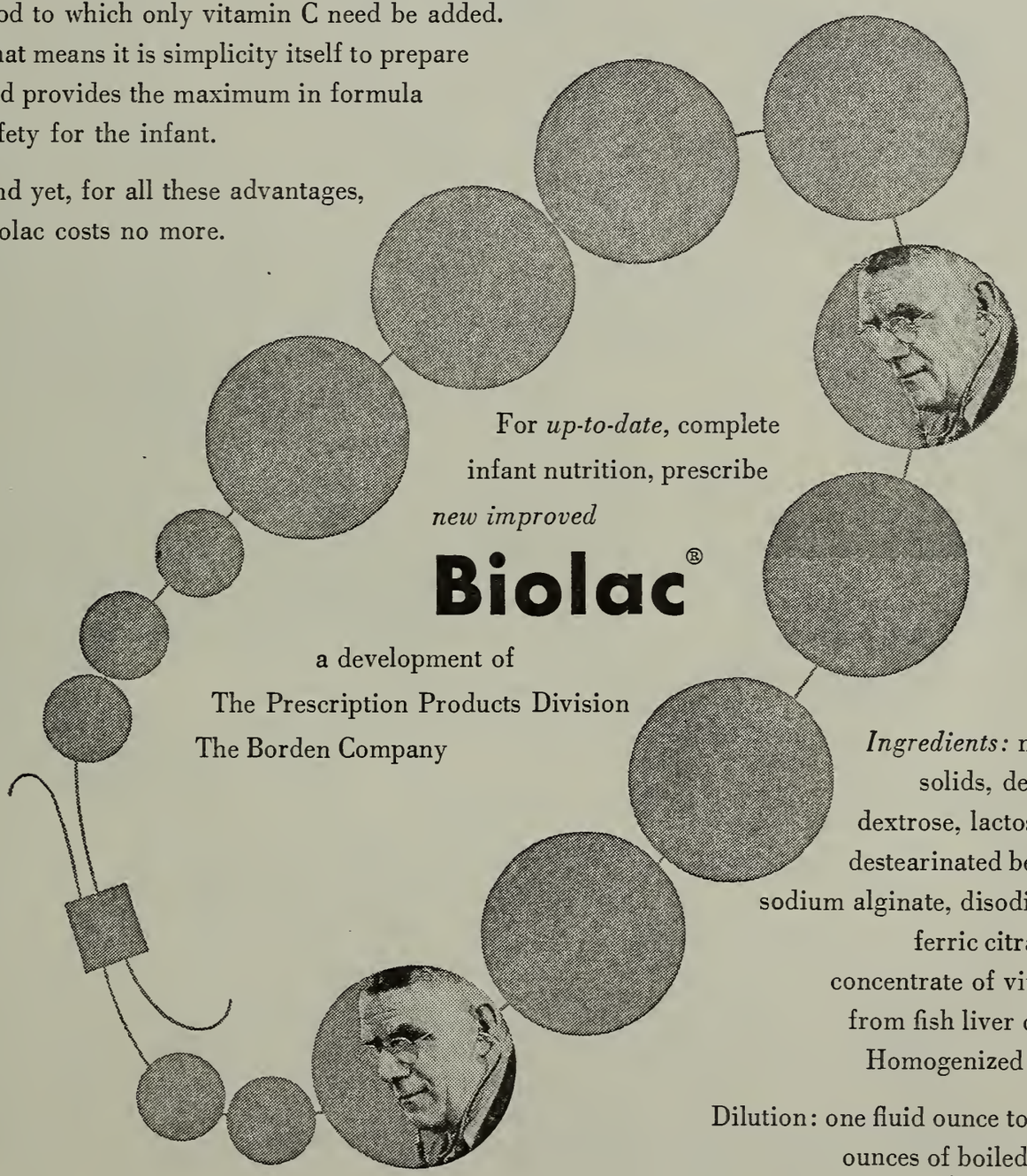
The University of Michigan School of Public Health, Ann Arbor, offers its first Inservice Training Course in Air Pollution, February 6-8. The School offers a series of inservice, non-credit training courses, of which the course in air pollution is the 33rd.

more physicians are satisfied

The development of the new improved Biolac supplies a long-sought need in infant nutrition. To accomplish this, Borden scientists surveyed our present nutritional knowledge. They then tested more than 500 formulations. Having decided on the formula that would best supply the normal infant's nutritional requirements in their most assimilable form, a modern plant was constructed in 1949 so that the new formula could also benefit from the most up-to-date techniques and control in processing equipment. A Biolac formula that is both new and improved is thus made available.

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Ingredients: nonfat dry milk solids, dextrins-maltose-dextrose, lactose, coconut oil, destearinated beef fat, lecithin, sodium alginate, disodium phosphate, ferric citrate, vitamin B_1, concentrate of vitamin A and D from fish liver oils, and water. Homogenized and sterilized.

Dilution: one fluid ounce to one and a half ounces of boiled water for each pound of body weight.

Biolac is available in 13 fluid ounce tins.

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In Memoriam . . .

Robert Harvey Cook, M. D., Oxford; Medical College of Ohio, Cincinnati, 1894; aged 78; died Nov. 24; former member of the Ohio State Medical Association and the American Medical Association through 1941; vice-president of the Butler County Medical Society in 1931; member American Psychiatric Association. Dr. Cook retired several years ago from active practice in Oxford where he was active in the affairs of Miami University. Recently he was awarded the Ohio State Medical Association's 50-Year Pin and Certificate at special ceremonies by the Butler County Medical Society. Surviving are two sons, Dr. Malcolm O. Cook of Hamilton and Dr. George H. Cook of Iona, Mich.

Earl Wellington Euans, M. D., Columbus; Ohio Medical University, Columbus, 1897; aged 78; died Nov. 26; former member of the Ohio State Medical Association and the American Medical Association through 1948. Dr. Euans spent his entire professional career in Columbus where he retired several years ago. He was a member of the Presbyterian Church and several Masonic orders. One brother survives.

George Bennett Faber, M. D., Columbus; University of Louisville School of Medicine, 1921; aged 62; died Nov. 14; former member of the Ohio State Medical Association and the American Medical Association in 1926. Dr. Faber, formerly with the Ohio Industrial Commission, retired from practice many years ago. Surviving are his widow, a son and a daughter.

Leroy R. Fast, M. D., Paulding; Barnes Medical College, St. Louis, Mo., 1898; aged 82; died Nov. 24; member of the Ohio State Medical Association and the American Medical Association; president of Paulding County Medical Society, 1920, 1927, 1931, 1939, 1940; vice-president, 1926; delegate 1922-25, 1929, 1930, 1933-38, 1941-43; chairman of the legislative committee, 1926, 1933-34. Dr. Fast had retired about a year ago after a lifetime practice in Paulding and vicinity. He was a veteran of World War I, during which he served with the Medical Corps overseas. Surviving are two daughters, two sisters and two brothers, one of whom is Dr. T. P. Fast of Grover Hill.

Ira B. Gordon, M. D., Cleveland; Pulte Medical College, Cincinnati, 1891; aged 79; died on or about Oct. 26; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1948.

Louis Guberman, M. D., Cincinnati; University of Berne (Switzerland) Faculty of Medicine, 1935; aged 40; member of the Ohio State Medical Association and the American Medical Association. Upon returning to the United States, after studying in Europe, Dr. Guberman spent two years at Mercy Hospital in Williamson, W. Va. He began practice in Cincinnati after taking the board examination in 1938.

William Barnes Litten, M. D., West Bedford; Columbus Medical College, 1880; aged 93; died Nov. 23; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1948. Dr. Litten began his practice in West Bedford in 1881 and continued until 1946 when he retired. Recently he was awarded the Ohio State Medical Association's Pin and Certificate for more than 50 years of medical practice. Dr. Litten's practice, especially in the earlier years, took him into Licking, Holmes, Knox, Tuscarawas and Muskingum Counties as well as Coshocton County. In addition to his medical work, he had many civic interests. He was one of the organizers and directors of the Coshocton bank now known as the First National Bank. He was active also in promotion of such projects as road improvement, education, the Red Cross, and was a life member of the Methodist Church. Surviving are his widow, and two daughters.

Joseph A. Murphy, M. D., Columbus Medical College, 1890; aged 81; died Dec. 11; former member of the Ohio State Medical Association and the American Medical Association in 1914. A practicing physician in Columbus for approximately 60 years, Dr. Murphy held the office of county coroner for several terms beginning in 1905 and again from 1921 to 1931. He was a member of several Masonic orders and was active in the Methodist Church. Surviving are his widow, two sons, four daughters, a brother and a sister.

William Elmer Radcliff, M. D., Caldwell; Indiana Medical College, School of Medicine of Purdue University, Indianapolis, 1906; aged 75; died Nov. 30; member of the Ohio State Medical Association and a Fellow of the American Medical Association; vice-president of the Washington County Medical Society in 1944; its president in 1945; delegate, 1942, 1946 and 1947. Dr. Radcliff had practiced medicine in Caldwell and vicinity for approximately 37 years. He held membership in several Masonic orders. His widow survives.

Clarence Scott Ramsey, M. D., Springfield; Jefferson Medical College of Philadelphia, 1900; aged 74; died Nov. 15; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Clark County Medical Society in 1935. Dr. Ramsey

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served his entire professional career in Springfield.

Samuel Rosenfeld, Jr., M. D., Columbus; Rush Medical College, University of Chicago, 1936; aged 42; died Dec. 7; member of the Ohio State Medical Association and a Fellow of the American Medical Association. In addition to his private practice, Dr. Rosenfeld was an associate professor in the Ohio State University College of Medicine, and was active in the work of the Columbus Cancer Clinic. He was a member of the Temple Israel Congregation. Surviving are his widow, two sons, a daughter, his father, two brothers and four sisters.

Elmer C. Sill, M. D., Hamilton; Medical College of Ohio, Cincinnati, 1888; aged 83; died Nov. 13; former member of the Ohio State Medical Association and the American Medical Association through 1923. Dr. Sill began his practice in Hamilton in the early 1890's, and recently was honored by the Butler County Medical Society by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. One son survives.

James Hickman Swan, M. D., Painesville; Northwestern University Medical School, 1923; aged 59; died Nov. 23; member of the Ohio State Medical Association and the American Medical Association. Dr. Swan practiced for several years in Cleveland before moving to Painesville in 1942. The son of a medical missionary in China, he had a colorful background of experiences in the Orient. He was a member of the Presbyterian Church. Surviving are his widow, a daughter, a son and two brothers, one of whom is Dr. Charles A. Swan of Cleveland.

Carl Tuttle, M. D., Berlin Heights; Western Reserve University School of Medicine, 1884; aged 88; died Nov. 27. Dr. Tuttle served his entire professional career in Berlin Heights and vicinity. In addition to his professional work, he found time to pursue several hobbies, especially as a naturalist. Surviving are a daughter-in-law and a sister.

Engineer Named

Appointment of W. Waldo Towne as chief basin engineer of the Ohio and Tennessee Drainage Basin was announced by the Federal security administrator. The Basin is a field operation of the Federal Security Agency's Public Health Service, with headquarters in Cincinnati.

One of his duties will be to assist States lying in the Ohio and Tennessee Drainage Basin area in developing comprehensive programs aimed at preventing or abating pollution of the basin's water resources. This activity is required by the Water Pollution Control Act of 1948, which establishes the authority for a national water pollution control program.

V. A. Can Pay But One Fee Unless Separate Service Is Rendered

Physicians caring for veterans under the Ohio Veterans Medical Care Program can be paid but one fee on the occasion of one visit, unless there is ample justification for an additional fee on the basis of additional service, according to notices being sent to physicians by the Veterans Administration Regional Offices at Cleveland and Cincinnati which are based on a ruling from the U. S. Comptroller General.

Physicians should bear this in mind in obtaining authorizations and in billing the Veterans Administration.

Following is a letter over the signature of Dr. H. P. Timberlake, chief medical officer of the Cleveland Regional Office, which explains in some detail the ruling and its effect:

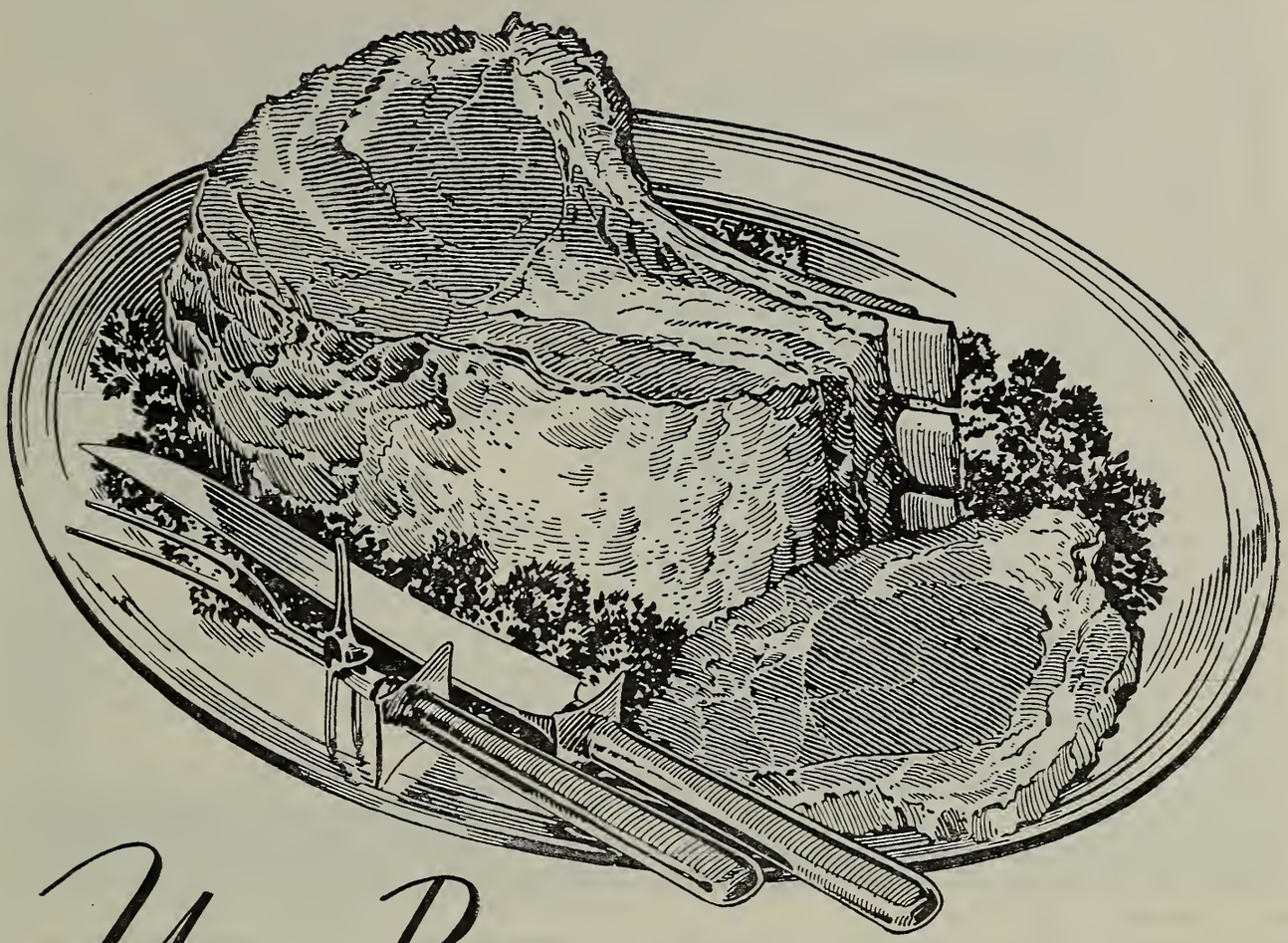
"The General Accounting Office, under the direction of The Comptroller General of the United States, is now sending notices of exceptions to Veterans Administration Regional Offices, calling attention to a decision that 'Fees for both office visits and injections may **not** be allowed when services are rendered jointly.' Even though authorized and paid, they will ask for recovery of the additional fee from either the participating physician or the Veterans Administration physician who authorized the service, unless an explanation is furnished which is acceptable to the General Accounting Office.

"This means that the Veterans Administration physicians issuing authorities can authorize but one fee on the occasion of one visit, unless there is ample justification for the additional fee on the basis of additional service. The greater of two possible fees is allowable. Furthermore, the additional service must be adequately explained on the Report of Treatment Rendered (Form 2690a) in order to justify the payment of the voucher.

"Although the inquiries at present usually involve combining Fee Schedule Items 0014 and 0056 with Items 8110 and 8111 (Visits and Injections), this will apply also to other possible dual requests; such as, combining a visit fee with an X-ray therapy fee or physical therapy fee.

"With respect to outstanding authorities, many months may elapse before the Veterans Administration receives a notice of the exception, so some designated physicians may be asked to furnish justification from old records if the report in the Veteran's treatment folder is inadequate.

"If expensive drugs or biologicals used in injections cannot be obtained conveniently from a V. A. pharmacy or a cooperating pharmacy and are actually furnished by the physicians, billing at actual cost may be added to the statement."



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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (April 2) 1949.

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First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

CLERMONT

Dr. David W. Heusinkveld, Cincinnati, Councilor of the First District of the Ohio State Medical Association, presented 50-Year Pins and Certificates to two doctors at the Nov. 16 meeting of the Clermont County Medical Society. Those who received the awards are Dr. A. C. Roberts of Loveland and Dr. J. P. Allen of Williamsburg.

Dr. E. O. Swartz, Cincinnati, President-Elect of the Association, also was a guest of honor at the meeting.

The meeting was held at the home of Dr. and Mrs. F. S. Skeen in Batavia.

HAMILTON

Dr. Harry Eagle, National Institute of Health, Bethesda, Md., spoke on the subject, "The Therapeutic and Prophylactic Use of Penicillin," at the Dec. 6 meeting of the Academy of Medicine of Cincinnati.

Included in the scheduled program of the Academy for January and February are the following speakers and subjects:

Jan. 3—Dr. Jacob E. Finesinger, University of Maryland, Baltimore, "The Psychiatric Aspects of Fatigue."

Jan. 17—Dr. Herrman L. Blumgart, Harvard Medical School, Boston, "The Pathogenesis of Angina Pectoris."

Feb. 7-8—Dr. Lawson Wilkins, Johns Hopkins University, Baltimore, (the B. K. Rachford Lecture), "Endocrine and Other Factors Concerned in Somatic Growth and Development," and "The Endocrine Problems of Sexual Development."

Feb. 21—Dr. Henry Schwartz, Washington University School of Medicine, St. Louis, "Surgical Relief of Pain."

HIGHLAND

The Highland County Medical Society honored five doctors at a banquet in Hillsboro for a half-century or more of service in the medical profession. Fifty-Year Pins and Certificates of the Ohio State Medical Association were presented at the meeting to Dr. W. H. Wilson, Greenfield; Dr. Thomas W. Roberts, Belfast; Dr. John A. Mercer, Greenfield; Dr. J. C. Larkin, Hillsboro; and Dr. Robert W. Pratt, Hillsboro. Drs. Mercer, Larkin and Pratt were unable to be present at the meeting.

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CLARK

Dr. C. Rollins Hanlon, Johns Hopkins University, spoke on "Surgery in Congenital Cardio-Vascular Disease," at the Nov. 21 meeting of the Clark County Medical Society at the Ker-Deen Inn.

DARKE

On Dec. 6, at the meeting of the Darke County Medical Society in Greenville, Dr. Merrill D. Prugh, Dayton, Councilor of the Second District of the Ohio State Medical Association, presided at presentation of Fifty-Year Awards to Drs. Brice F. Metcalfe, Orlando P. Wolverton and William C. Gutermuth.

Dr. Giles Wolverton, Dayton, placed the pin on the lapel of his father, while Dr. J. E. Gillette, Versailles, placed the pin for his father-in-law, Dr. Gutermuth. Dr. R. D. Dooley, Dayton, president of the Second District, gave a short talk.

GREENE

The brick-laying ceremony at the site of the new Greene County Memorial Hospital Nov. 20 was the occasion for presentation of 50-Year Pins and Certificates to three Greene County physi-



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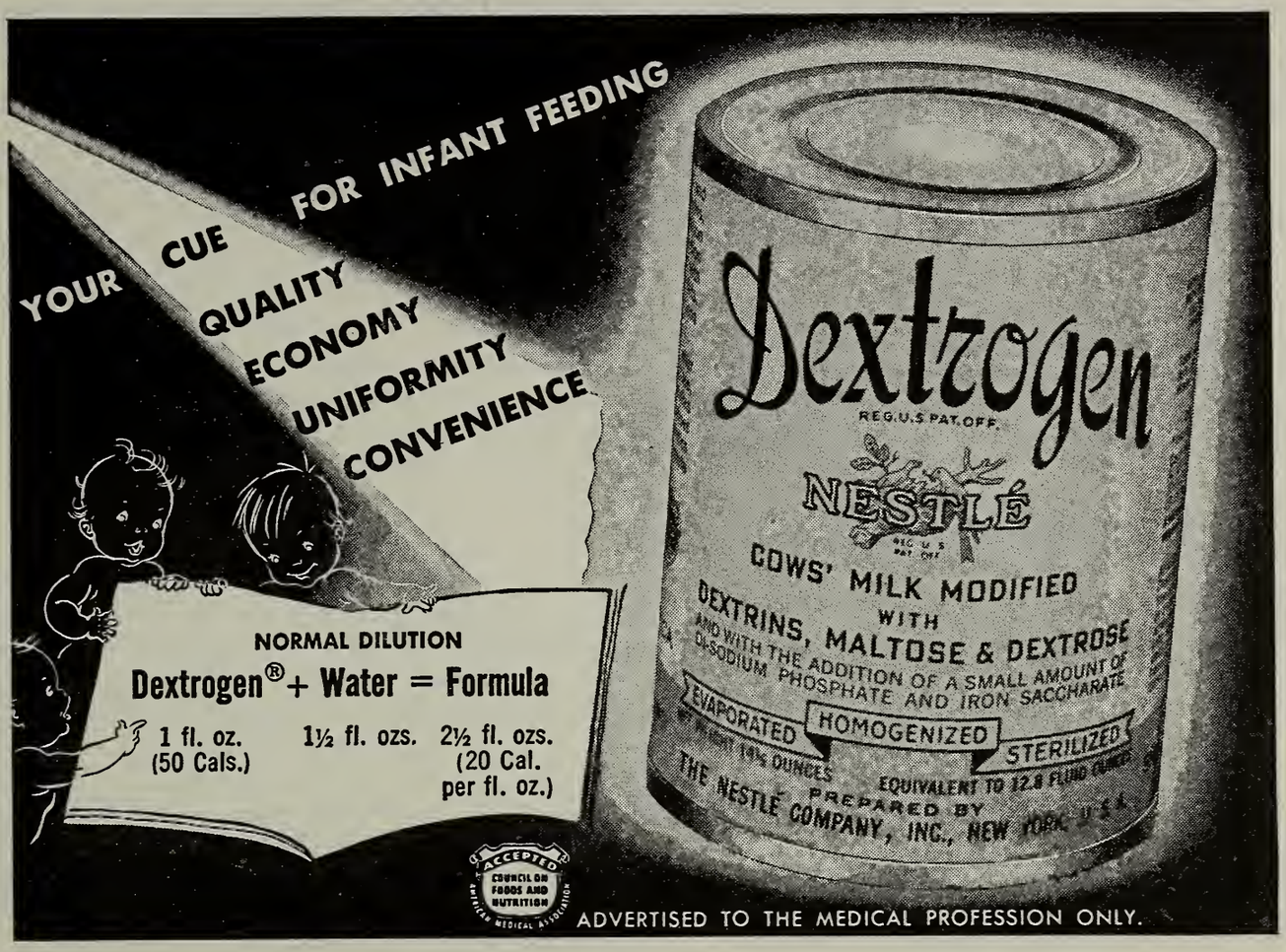
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cians. They are Dr. C. W. Miller, Osborn; Dr. C. E. Ream, Towersville and Dr. L. L. Taylor, Yellow Springs. Dr. C. K. Schloss, Osborn, president of the Greene County Medical Society, made the presentations. Dr. Miller was unable to be present at the meeting, but a representative accepted the award for him. Dr. R. Kent Finley of Dayton was principal speaker at the occasion.

MIAMI

Dr. Melvin Oosting of the Troy and Piqua Hospitals presented a clinical session on the primary points of consideration in the diagnosis of anaemias at the Dec. 2 meeting of the Miami County Medical Society, at the Stouder Memorial Hospital, Troy.

MONTGOMERY

Two scientific papers were presented before the Eye, Ear, Nose and Throat Section of the Montgomery County Medical Society on Nov. 8. Dr. J. T. Bickmore, Dayton, spoke on "Nasal Physiology," and Dr. M. W. Sloan, also of Dayton, spoke on the subject, "Surgery and Orthoptic Treatment of Children with Eye Muscle Conditions."

The following Section officers were elected: Dr. Robert A. Bruce, Dayton, president; Dr. A. W. McCally, Dayton, vice-president, and Dr. L. N. Shroder, Greenville, re-elected secretary-treasurer.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D., UPPER SANDUSKY)

AUGLAIZE

Members of the Mercer County Medical Society were guests of the Auglaize County Medical Society at a meeting on Oct. 13. Speaker for the occasion was Dr. H. C. Weisenbarger of Lima who spoke on the subject of kidney and bladder pathology.

HANCOCK

Dr. J. Craig Bowman, Upper Sandusky, Councilor of the Third District of the Ohio State Medical Association, presented the Association's 50-Year Pins and Certificates to three doctors at the November meeting of the Hancock County Medical Society. They are Dr. T. W. Wilson, Findlay; Dr. R. N. Lee, Mt. Blanchard, and Dr. W. F. Lehr, Arlington.

HARDIN

Dr. Dwight M. Palmer, Ohio State University College of Medicine, addressed a meeting of the Hardin County Medical Society at Kenton on Nov. 17. Dr. Palmer's discussion was in the field of psychiatry and neurology.

LOGAN

The Logan County Medical Society held a dinner meeting at Hotel Ingalls, Bellefontaine, on Nov. 4, at which Dr. Joseph L. Morton of Columbus was guest speaker.

MARION

Dr. J. Craig Bowman, Upper Sandusky, Councilor of the Third District of the Ohio State Medical Association, presented 50-Year Pins and Certificates to eligible doctors at the Nov. 8 meeting of the Marion County Academy of Medicine. Those who received the awards were: Dr. Charles W. Jacoby, Dr. Richard L. Morgan, Dr. Herman S. Rhu, Sr., Dr. Neuman Sifritt, Dr. Arthur J. Willey, all of Marion, and Dr. Benjamin D. Osborn of Waldo. Dr. Albert Starner was unable to be present, but his pin and certificate were given to Dr. A. E. Morrison, president of the local society, for conveyance.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M.D., TOLEDO)

WOOD

Dr. William H. Rheinfrank of Perrysburg, Dr. Frank D. Halleck of Bowling Green and the widow of the late Dr. William H. Price of Stony Ridge were the recipients of gold medals and Certificates of Distinction in honor of the physicians having been actively engaged in the practice of medicine for over 50 years. Mrs. Price received the Medal for her deceased husband.

The presentation was made by Dr. Paul F. Orr of Perrysburg at the regular meeting of the Wood County Medical Society held at the

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Midway Night Club, Dixie Highway, Perrysburg. The physicians were joined by their wives and members of the Auxiliary, representatives of the Press and friends.

Mrs. Florence Price, widow of Dr. William H. Price, expressed her great appreciation of the honor paid her husband. She was accompanied by her son, Dr. Frederick F. Price, of Stony Ridge. Dr. Halleck and Dr. Rheinfrank responded briefly attesting their gratitude. Mrs. H. W. Mannhardt, president of the Auxiliary, spoke of the new scholarships available to graduate nurses for further work.

Dr. Carll S. Mundy, chairman of the Rural Health Committee and Councilor for the Fourth District of the Ohio State Medical Association, gave the paper of the evening on "Medicine Past and Future."

Dr. Mundy reviewed the progress of medicine since the turn of the century emphasizing the increasing interest in preventive measures and the newer drugs and procedures. He spoke of the changes wrought in practice by the improved transportation enabling physicians to cover a much wider territory in the care of the sick. Many compliments were expressed on Dr. Mundy's clear discussion of social medical progress.

At the business meeting Dr. Raymond N. Whitehead of Bowling Green was elected president; Dr. J. R. McAuley of Perrysburg was elected vice-president, and Dr. Roger A. Peatee of Bowling Green secretary-treasurer.

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

CUYAHOGA

A series of Sunday afternoon health lectures, open to the public is being sponsored by the Academy of Medicine of Cleveland at the Medical Library Auditorium. Included in the schedule are the following:

Jan. 15—"Tales That Dead Men Tell," Dr. Alan R. Moritz; Feb. 5—"Atomic Energy in Medicine," Dr. Hymer L. Friedell and Dr. George L. Sackett; Feb. 26—"Viruses, Man's Smallest Living Enemies," Dr. John H. Dingle; March 19—"What Makes Your Baby Grow," Dr. Richard G. Hodges. All speakers are of Western Reserve University School of Medicine.

The Academy scientific program for December included the following:

Dec. 2—Clinical and Pathological Section—"Auricular Fibrillation as a Toxic Complication of Pneumonia," Drs. Frederick Geist and Henry A. Zimmerman; "Exertion Hemoglobinuria," Dr. Bert Peppercorn and Dr. Zimmerman; "Fulminat-

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ing Infectious Hepatitis," Drs. Donald Adair, Arthur F. Young and Zimmerman; "Action of Digitalis in Patients With Large Hearts and Congestive Failure," Drs. Joseph M. Ryan and Zimmerman.

Dec. 7, Pediatric Section—"Experimental Production of Macrocytic Anemia," Dr. Charles D. May, University of Minnesota Medical School.

Dec. 9—Experimental Medicine Section of the Academy and Section of the Society for Experimental Biology and Medicine—"BAL and Testosterone Proprionate of Mercuric Chloride Poisoning," Drs. Richard P. Levy, Thomas W. Moir and Max Miller; "Production of Diabetes With Vitamin C Derivatives," Dr. J. W. Patterson; "Methylene Blue Potentiation of Alloxan Diabetes," A. Lazarow, Ph. D., S. Stephens and J. Liambeis. All of the foregoing speakers are of Western Reserve University.

Dec. 16—Regular Academy Meeting—"What's New in Drugs?" by Dr. E. M. K. Geiling, University of Chicago.

LAKE

Four Lake County physicians were honored with the 50-Year Pin and Certificate of the Ohio State Medical Association at the Nov. 29 annual Lake County Memorial Hospital staff dinner. Dr. Fred W. Dixon, Cleveland, Councilor of the Fifth District of the Ohio State Medical Association, made the presentations in the name of the Association. Those who received pins are Dr. Phrania Chesbrough, Willoughby; Dr. Jules Verne Winans, Madison, and Dr. Chauncey O. Hudson, Painesville. Dr. Michael H. Carmody was honored posthumously.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

COLUMBIANA

Officers of the Columbiana County Medical Society for the coming year are: Dr. Ralph J. Starbuck, president; Dr. R. J. McConnor, vice-president; and Dr. Harold F. Hoprich, secretary-treasurer. All are of Salem.

STARK

Among members of the Stark County Medical Society eligible for the 50-Year Pin and Certificate are the following who were presented the awards at a meeting of the Canton Academy of Medicine:

Dr. C. A. Crane, Dr. F. E. Hart, Dr. G. E. Paolazzi, Dr. J. A. Schirack and Dr. W. A. White, Sr. Presentations were made by Dr. Carl A. Lincke, Carrollton, President of the Ohio State Medical Association. Dr. Esther Tyrrell and Dr. Herman Welland were unable to be present to receive the awards.

TRUMBULL

The annual postgraduate day of the Trumbull County Medical Society was held at the Ameri-

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can Legion Hall in Warren on Nov. 16. Included on the scientific program were four doctors from the University of Michigan Medical School: Dr. H. R. Morgan who discussed the management of intestinal upsets; Dr. S. W. Hoobler who discussed treatment of elderly patients with heart ailments; Dr. R. L. Haas whose subject was in the field of obstetrics and gynecology; and Dr. H. K. Ransom who spoke on ulcerative colitis and other diseases of the colon.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

The Dec. 15 meeting of the Belmont County Medical Society was held at the Belmont Hills Country Club. Included on the program was the showing of a film entitled "Treatment of Gastric Ulcers," by Dr. Peter Lancione of Bellaire and a talk by Dr. H. E. Hathhorn, Youngstown, on the subject, "Water and Electrolyte Balance."

After dinner with the Auxiliary, Wayne L. Mays, Representative from the 18th Congressional District, discussed experiences on his recent trip to Europe.

COSHOCTON

Three Coshocton County doctors were honored with 50-Year Pins and Certificates of the Ohio State Medical Association at a dinner meeting of the Coshocton County Medical Society and their wives. The three doctors are Dr. E. M. Wright, Coshocton; Dr. E. U. Marquand, Coshocton, and Dr. W. B. Litten, (since deceased). Of the three, only Dr. Wright was able to be present at the meeting. Dr. R. J. Foster, New Philadelphia, Councilor of the Seventh District of the Ohio State Medical Association, made the presentation.

TUSCARAWAS

Three doctors, Dr. E. B. Shanley, New Philadelphia, Dr. D. W. Shumaker of Dover, and Dr. R. A. Wilson of Dennison, were honored at the Nov. 16 meeting of the Tuscarawas County Medical Society for fifty or more years of service in the medical profession. The dinner meeting was held in the Elks dining room in New Philadelphia.

Dr. C. D. Kurtz of New Philadelphia, also eligible for the award, was unable to attend because of illness.

Dr. R. J. Foster, New Philadelphia, Councilor of the Seventh District of the Ohio State Medical Association, made the presentation in the name of the Association.

Dr. Carl A. Lincke, Carrollton, President of the Association, gave a congratulatory talk to the 50-year doctors. Dr. C. M. Dougherty, president of the local society, presided.

Guest speaker for the evening was Dr. Donald B. Effler, Cleveland, who discussed chest surgery.



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During the dinner, a trio composed of Jeanne Ball and Mrs. Foster Flora of New Philadelphia and Gilbert Roehm of Dover provided music, while vocal selections were given by Miss Margaret Ann Davis and James Baker accompanied by Mrs. Ruth Jurgens, all of Dover. Dr. E. C. Davis, Jr., was program chairman.

The following officers were elected for the ensuing year: Dr. William E. Hudson, New Philadelphia, president; Dr. Vincent C. Nipple of Midvale, vice-president, and Dr. H. F. Wherley, New Philadelphia, secretary-treasurer.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M. D., LANCASTER)

FAIRFIELD

Dr. Mel A. Davis, Columbus, spoke to members of the Fairfield County Medical Society at a luncheon meeting in Hotel Lancaster on the subject, "Early Recognition of Cancer."

Walter E. Brehm, Millersport, representative of the Eleventh Ohio Congressional District, spoke at the Dec. 13 meeting.

GUERNSEY

Dr. Wilmer G. Lane, Cambridge, was honored at a meeting of the Cambridge Rotary Club by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. The presentation was made by Dr. Chester P. Swett, Lancaster, Councilor of the Eighth District of the Association. Dr. George F. Swan spoke in behalf of the Guernsey County Medical Society at the conclusion of which he presented to Dr. and Mrs. Lane in the name of the members a bouquet of flowers.

At the Nov. 17 meeting of the Society, Dr. J. W. Camp spoke on the subject, "Diagnoses and Treatment of Rheumatoid Arthritis." Drs. F. G. Lawyer, Earl E. Conway and M. C. McCuskey were appointed a committee to arrange for a Christmas party for members and wives.

Election was held at the Dec. 1 meeting of the Society with the following officers elected: Dr. Reo M. Swan, president, and Dr. F. Gordon Lawyer, secretary-treasurer. The elected delegate is Dr. Robert A. Ringer and the alternate, Dr. Benjamin S. Gillespie. The scientific program was in charge of Dr. C. F. Shively who gave a talk on "Erythroblastosis Fetalis."

LICKING

Members of the Licking County Medical Society and the Auxiliary met for dinner at the Granville Inn on Nov. 29, after which they went to the Ohio Power Building where Dr. Robert E. S. Young, Columbus, spoke on the subject of "Socialized Medicine."

MUSKINGUM

Four physicians were honored at the Dec. 1 Christmas Party of the Muskingum Academy of Medicine by being awarded the Ohio State Medical Association 50-Year Pins and Certificates. They are: Dr. W. C. Bateman, Dr. G. W. McCormick, Dr. L. R. Culbertson and Dr. E. M. Brown, all of Zanesville. Dr. Beatrice T. Hagen, retiring county health commissioner, was honored for her many years of service in that capacity. Dr. Chester P. Swett, Lancaster, Councilor of the Eighth District of the Ohio State Medical Association, made the presentations.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

HOCKING

On the occasion of his 82nd birthday, Dr. A. K. Smith of Logan was presented the 50-Year Pin and Certificate of the Ohio State Medical Association by Dr. J. Ward Doering, president of the Hocking County Medical Society, and Dr. Owen F. Yaw, secretary. The ceremony of the presentation was in Dr. Smith's office where he still practices.

SCIOTO

Four local physicians were honored at the annual banquet of the Hempstead Academy of Medicine on Dec. 1 at the Chez Paree. Dr. J. P. McAfee, Councilor of the Ninth District of the Ohio State Medical Association, made presentations of the Association's 50-Year Pins and Certificates. The awards were presented to Dr. W. A. Ray, Dr. A. L. Test, Dr. D. A. Berndt, and Dr. J. W. Fitch.

New president of the Academy is Dr. L. B. Hatch of South Webster, who was installed to succeed Dr. Ross M. Gault. Dr. R. L. Wagner was installed as vice-president, succeeding Dr. Chester H. Allen, and Dr. C. L. Pitcher was reinstalled as secretary-treasurer. The Woman's Auxiliary gave a pictorial presentation as a feature of the program. Chairman and toastmaster for the occasion was Dr. Clyde W. Everett.

Dr. Arthur S. Jones of Huntington, W. Va., was guest speaker at the Dec. 12 meeting of the Academy where he spoke on the subject, "After Treatment of Poliomyelitis and Other Orthopedic Conditions."

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

Presentations of the Ohio State Medical Association's 50-Year Pins and Certificates to eligible members were made at the Dec. 13 meeting of the Lorain County Medical Society in Pueblo. The presentations were made by Dr. John S. Hattery, Mansfield, Councilor of the Eleventh District of the Association. Those who received pins are: Dr. F. B. Gregg, Wellington; Dr. H. J. Austin, Elyria; Dr. George Gill, Elyria; Dr. O. B. Monosmith, Lorain; Dr. S. V. Burley,

Lorain. The award was made posthumously to the late Dr. Emil J. Heinig.

MEDINA

Dr. Claude S. Perry, Columbus, was guest speaker at the Nov. 17 meeting of the Medina County Medical Society. His subject was "Office Ophthalmology."

Three members of the Society were awarded the 50-Year Pins and Certificates of the Ohio State Medical Association at the Dec. 15 meeting of the group at Wadsworth Municipal Hospital. They are Dr. R. L. Johnson of Wadsworth, Dr. Harry Streett of LeRoy, and the late Dr. H. P. H. Robinson of Medina.

RICHLAND

A combined meeting of the Richland County Medical Society and the active staff of Mansfield General Hospital was held at the hospital on Nov. 17. A dinner meeting was followed by a scientific program. Speaker on this occasion was Dr. Laurence S. Fallis, of the Henry Ford Hospital, Detroit, Mich. His subject was "Surgical Diseases of the Pancreas."

WAYNE

Four Wayne County physicians were awarded the 50-Year Service Pins and Certificates of the Ohio State Medical Association. They are: Dr. Lincoln A. Yocum, Wooster; Dr. Seymour G. Boor, Creston; Dr. William D. Wise, Orrville; and Dr. R. C. Paul, Wooster.

Woman's Auxiliary . . .

By MRS. S. L. MELTZER, Chairman, Publicity Committee
2442 DORMAN DRIVE, PORTSMOUTH

(Editor's Note—The reports for Scioto, Trumbull and Tuscarawas Counties and the October notes for Williams County were written for the December issue, but due to lack of space were held over to January.)

ALLEN

Fifty-five tables were in play at the annual benefit card party given by the Auxiliary to the Lima and Allen County Academy of Medicine on Nov. 16. The scene of the benefit was the Nurses' Home at Memorial Hospital. Individual table awards were given. Arrangements were in charge of Mrs. James McBride and Mrs. Donald English. Proceeds go to the auxiliary's nursing scholarship fund.

ASHTABULA

The first meeting of the 1949-50 season of the Woman's Auxiliary to the Ashtabula County Medical Society was a tea on Oct. 11 at the home of the President, Mrs. Frank Veroni. Following the business meeting, Mrs. John Guernieri entertained with piano selections. Tea was served by the hostess who was assisted by Mrs. Paul Longaker, Mrs. E. N. Wright and Mrs. H. A. Tagett.

On Nov. 8, the Ashtabula Auxiliary held a

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dinner meeting at the Hotel Cleveland at Conneaut. Mrs. C. T. Risley served as chairman of arrangements, assisted by Mrs. S. E. Gates, Mrs. J. G. Constantine and Mrs. R. C. Irving. Members discussed plans for the Thanksgiving dance on Nov. 26 at the Hotel Ashtabula. George Nash of Gansie Doll Hospital was the speaker and displayed several dolls.

General chairman of the Thanksgiving dance was Mrs. William H. Eberle. Proceeds of the dance have been applied to the nurse scholarship fund which the auxiliary has established. It is planned to make the dance an annual event.

CHAMPAIGN

Another new county auxiliary was added to the roster of state membership when the Woman's Auxiliary to the Champaign County Medical Society was organized on Nov. 29, at a luncheon in Urbana. Mrs. George Cooperrider, state president-elect, and Mrs. E. P. Greenawalt district director, met with the wives of the Champaign County physicians to assist them in their organization.

Mrs. V. R. Frederick was elected president; Mrs. F. E. Lowry, vice-president; Mrs. F. R. Grogan, secretary and treasurer.

CLARK

On Nov. 10, the Woman's Auxiliary to the Clark County Medical Society entertained at a musicale and tea held in the Nurses' Residence of Springfield City Hospital. Mrs. T. M. Hayes, chairman of Ways and Means, supervised the arrangements for the benefit assisted by a committee of seven. Guest artist was Howard Tuvelle, talented fifteen-year-old pianist who won top honors in the 1949 Young Artists' Competition sponsored last May by the Springfield Symphony Orchestra. Also on the program were numbers sung by the nurses' choir under the direction of Mrs. John E. Foster.

Members of the Clark County Auxiliary joined their husbands at an informal dinner party on Dec. 7 at the Springfield Country Club. Guest speaker was Harry E. Northam of Chicago, executive secretary of the Association of Physicians and Surgeons. Mrs. M. B. Martin was hospitality chairman.

ERIE

The November luncheon and meeting of the Erie County Auxiliary featured the history and workings of "The Welcome Wagon," a popular service originated by T. W. Briggs.

During the business session conducted by the President, Mrs. Carl E. Swanbeck, committee chairmen submitted reports and three new members were given the auxiliary pledge. The new members are Mrs. E. J. Baxter, Mrs. H. E. Snedden and Mrs. L. G. Parker. Then followed the introduction of transfer member, Mrs. J. Ohlemacher, formerly of Jamestown, Pennsyl-

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GYNECOLOGY—Intensive Course, two weeks, starting Feb. 20. Vaginal Approach to Pelvic Surgery, one week, starting March 6.

OBSTETRICS—Intensive Course, two weeks, starting March 6.

PEDIATRICS—Intensive Course, two weeks, starting April 3. Personal Course in Cerebral Palsy, two weeks, starting July 31.

MEDICINE—Intensive General Course, two weeks, starting April 24. Hematology, one week, starting May 8. Gastro-Enterology, two weeks, starting May 15. Liver & Biliary Diseases, one week, starting June 5. Gastroscopy, two weeks, starting Mar. 6.

DERMATOLOGY—Formal Course, two weeks, starting May 8. Informal Clinical Course every two weeks.

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vania. Plans were announced for a Christmas tea for the nursing staffs of Good Samaritan and Providence Hospitals.

FAIRFIELD

The Auxiliary to the Fairfield County Medical Society met on Nov. 14 at the Hotel Lancaster. Dessert was served and then a short business session followed, at which Mrs. F. W. James, president, presided. A comprehensive legislative report was given by Mrs. H. M. Amstutz, in which all the current bills before the present Congress were discussed. During the social hour, bridge was played. Hostesses for the occasion included Mrs. A. M. Kelly, Mrs. James, Mrs. J. A. Geer, Mrs. A. B. Van Gundy and Mrs. Charles Clark.

FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine held a day-long series of special events on Nov. 21 at the Deshler-Wallick Hotel. A book review opened the day's activities at 10:30 a.m. An English breakfast was served at noon. An afternoon bridge party featured a style show of furs. Proceeds from the day were turned over to the auxiliary's project which provides occupational therapy supplies to hospitals and other institutions in Franklin County.

In charge of arrangements were Mrs. Joseph H. Geyer, general chairman; Mrs. Joseph S. Stevens, ticket chairman; Mrs. Ben R. Kirkendall, prize chairman; Mrs. Zeph J. R. Hollenbeck, book review chairman; Mrs. Bruce C. Martin, breakfast chairman.

JEFFERSON

The Jefferson County Auxiliary played hostess at a dinner meeting on Nov. 10 at the Steubenville Country Club for the Jefferson County Medical Society. Three doctors of the Steubenville district were honored that night for a half-century of service in the medical profession. They were Dr. J. E. Miller, Dr. I. C. Foster and Dr. J. F. Young.

Covers were laid for 55 with a Thanksgiving theme used for table decorations. The committee in charge of arrangements included Mrs. E. Weinman, program chairman; Mrs. Robert Puncheon, Jr., and Mrs. S. Harris. Mrs. Albert Sunseri was social chairman; she was assisted by Mrs. Fred Harrington, Mrs. Ernest Perri and Mrs. David Greenberg.

LAWRENCE

Another new auxiliary to be welcomed is that of the Lawrence County Medical Society which was organized on Dec. 2. On that date, the doctors' wives of Lawrence County met at the home of Mrs. W. F. Marting, with Mrs. George Cooperrider, state president-elect. Mrs. Cooperrider explained the importance and advantages

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of the auxiliary, and after a period of discussion, the decision to organize was unanimous. Meetings are to be held on the third Monday of each month. The newly elected officers include: Mrs. George N. Spears, president; Mrs. John A. Dole, president-elect; Mrs. V. V. Smith, vice-president; Mrs. F. R. Stewart, secretary-treasurer.

LICKING

Thirty members of the Licking County Medical Society and their wives met at Granville Inn for dinner on Nov. 29. The group later went on to the Ohio Power building to hear Dr. Robert E. S. Young of Columbus speak on socialized medicine. In the audience, besides the medical society and its auxiliary, were druggists, nurses, dentists and hospital personnel. Dr. Young pointed out the pitfalls that the various countries have fallen into as a result of their attempt to socialize the practice of medicine.

LUCAS

An open tea featured the Nov. 15 meeting of the Woman's Auxiliary to the Toledo and Lucas County Medical Society at the Woman's Club. Friends and guests of auxiliary members were invited to hear Judge Paul Alexander talk on "What Is Happening to Family Life?" Mrs. Harry Conn of the program committee introduced the speaker. The auxiliary's public relations group also worked with the Family Council and P. T. A. Council in bringing a physician speaker to address an open meeting that was held in the Academy of Medicine building on Nov. 17.

OTTAWA

Thanksgiving and Christmas tray decorations for Magruder Hospital patients were made by members of the Woman's Auxiliary to the Ottawa County Medical Society when they met on Nov. 17 at the home of Dr. and Mrs. LeRoy Belt. After a short business session, a program was presented by Mrs. C. R. Wood who conducted a discussion of the "Voluntary Way." The women also assembled tuberculosis seal envelopes that evening.

RICHLAND

The auxiliary to the Richland County Medical Society held a luncheon and social meeting on Dec. 5 at the Women's Club. Forty members and one guest were present. Christmas appointments decorated the luncheon tables. Mrs. F. J. Heringhaus, president, conducted the business meeting. Mrs. Russell Barnes reported that the ice cream and candy sent to the Richland County Home was enjoyed and appreciated by the residents.

It was announced that the auxiliary will assist the Health Department with clerical work connected with the hearing program. A new member, Mrs. Kenneth Werts, was welcomed into the



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group. Following the business meeting, bridge was played.

SANDUSKY

Harry C. Heffner, author and lecturer, spoke on "Health—the American Way" in a special program held at the Memorial Hospital Nurses' Home on Nov. 29, sponsored by the Sandusky County Auxiliary.

This meeting was open to the public. Mr. Heffner presented his ideas as a layman regarding the health insurance program, and provided a detailed and informative outline of the vital issue facing the United States citizenry today. "Compulsory health insurance isn't just a threat to health," he pointed out, "it is a threat to freedom."

At the conclusion of Mr. Heffner's talk, it was announced to auxiliary members that a Christmas party had been planned at the home of Mrs. F. L. Moore on Dec. 16.

SCIOTO

The Scioto County Auxiliary voted, at its November meeting, to start a special nurse recruitment fund, the proceeds from which will be used to sponsor a deserving girl from the Hillcrest Home for Children in Scioto County through nurse's training. The meeting was held at the Four Keys in the form of a luncheon on Nov. 9. Mrs. W. A. Ray, president, presided at the business session. A social hour concluded the meeting. A bake sale was also a feature of the afternoon.

TRUMBULL

The first session of the fall season for the auxiliary of the Trumbull County Medical Society was a joint dinner meeting with the members of the Medical Society at the El Rio on Sept. 24.

Dr. R. P. Ostergard introduced the guest speaker, Dr. Samuel Spector, assistant professor of pediatrics at Babies' and Children's Hospital in Cleveland. Following the lecture, the individual groups adjourned to their respective business meetings.

Mrs. D. R. Mathie, president, introduced her new officers: president-elect, Mrs. A. W. Beale; vice-president, Mrs. Clyde Muter; corresponding secretary, Mrs. Allen Shaffer; recording secretary, Mrs. John Thomas; treasurer, Mrs. Charles Mathias.

The auxiliary met on Oct. 21 at the Trumbull Country Club for a luncheon meeting. Mrs. Mathie presided over the business period. Miss Janet Zizelman of Cleveland spoke on "Contemporary Modern Interior Decoration." She was introduced by Mrs. E. G. Kyle, program chairman. Miss Brant of Harding High School, representing the citizenship committee, talked on the school levy.

TUSCARAWAS

The Woman's Auxiliary to the Tuscarawas County Medical Society held its September meeting at the home of Dr. and Mrs. William Hudson. Mrs. M. W. Everhard, president, presided at the business meeting. A nominating committee headed by Mrs. C. J. Miller was appointed. Plans for the winter season were discussed.

WILLIAMS

Mrs. J. A. Maxwell has been elected president of the recently formed Auxiliary to the Williams County Medical Society. Other officers include: Mrs. R. K. Ameter, president-elect; Mrs. Victor Boerger, vice-president; Mrs. J. R. Riesen, secre-

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tary; Mrs. W. L. Hahn, treasurer. Mrs. Ameter and Mrs. Maxwell were hostesses at a luncheon held on Oct. 11 at the Hotel Elder. This was followed by a business meeting at the home of Mrs. Ameter. Guests were Mrs. George Cooperrider, state president elect, and Mrs. Cyrus Wood, district director. Meetings will be held once each month.

The Woman's Auxiliary to the Williams County Medical Society held its November meeting at the home of Mrs. J. A. Maxwell at Montpelier. It was announced that Mrs. R. K. Ameter and Mrs. Maxwell had attended the annual conference for presidents and presidents-elect held in October in Columbus. Later in the evening, the doctors joined their wives at the Maxwell home.

A. M. A. Council Warns Against Unwise Use of Cold Tablets

The Council on Pharmacy and Chemistry of the American Medical Association warned against indiscriminate use of antihistaminic substances now being widely promoted for prevention and treatment of colds.

"The council recognizes the evidence that has been accumulated relative to such uses but it is not convinced that this is sufficient to warrant the positive statements that are being made," the Council said.

"Cases already are reported and records show that about one-third of those who take these drugs become drowsy or even fall asleep while at work or in occasional cases even when driving cars or operating machinery.

"Experience with these drugs is not yet long enough to know whether or not they are harmless when used over long periods of time. Furthermore, the amounts taken in persistent colds may be definitely beyond what has been established as safe."

COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Cleveland, May 16-18.

American Medical Association, Annual Session, San Francisco, Calif., June 26-30.

National Conference on Rural Health, Kansas City, Mo., Feb. 3-4.

American Academy of General Practice, St. Louis, Feb. 20-23.

American Association for Thoracic Surgery, Denver, Colo., April 15-19.

American College of Physicians, Boston, April 17-21.

American College of Radiology, San Francisco, Calif., June 25.

American Pediatric Society, French Lick, Ind., May 8-10.

National Tuberculosis Association, Washington, D. C., April 25-28 .

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

A Textbook of Physiology, edited by John F. Fulton, M. D. ($10.00. *W. B. Saunders Company, Philadelphia),* is the sixteenth edition of the old, old *Howell Physiology* which your reviewer used when he was in school 40-some years ago. It has a new editor and a whole new list of collaborators which keep it still one of the best texts for medical men.

Health Guides and Guards, by Francis P. Wall and Louis D. Zeidberg ($4.00. Fourth Edition. *Prentice-Hall, Inc., New York City),* is an effort to keep up with the strides made in sanitation during the war years and to meet the demand upon the authors. This book has been revised three times in the last thirteen years. This speaks for the quality of the text.

A Textbook of Surgery, by American Authors, edited by Frederick Christopher, M. D. ($13.00. Fifth Edition. *W. B. Saunders Company, Philadelphia).* Our fellow members, Beck of Cleveland; Altemeier of Cincinnati; Curtis of Columbus; Harbin of Cleveland; Herrmann of Cincinnati; Hoerr of Columbus; and Zollinger of Columbus, have all contributed chapters on subjects in which they are especially interested. The authors again have successfully based their material on the tried and the true.

Change of Life—A Modern Woman's Guide, by F. S. Edsall ($2.00. *Woman's Press, New York City).* From the viewpoint of one who has to listen to so many otherwise intelligent women talk about their age as though there was something pathologic about age itself, this book gives those who are able to profit by what they read, an excellent bit of advice.

Arterial Hypertension, by Irvine H. Page, M. D., and Arthur Curtis Corcoran, M. D. ($5.75. Second Edition. *Year Book Publishers, Inc., Chicago),* is a practical manual for the care of the patient with hypertension presented for those of us who are interested in such patients but not to the exclusion of patients with other afflictions. These Ohio physicians have made us deeply obligated to them.

Clinical Audiology, by Maurice Saltzman, M. D. ($5.00. *Grune and Stratton, Inc., New York City),* deals with physics and psychology in an attempt to clear up some of the problems of impaired hearing and diseases of the ear. The author is a well-known expert in this narrow field of hearing.

Atlas of Surgical Operations, by Elliott C. Cutler and Robert M. Zollinger, illustrated by Mildred B. Codding ($9.00. *Macmillan Company, New York City),* is a revised edition of this excellent atlas and contains 30 new procedures in addition to the original ones, about half of whose plates have been redrawn to their improvement.

Acute Laryngotracheobronchitis, by A. Harry Neffson, M. D. ($5.00. *Grune and Stratton, Inc., New York City),* is the first monograph on "croup" in years. The author tries, in this small volume, to clarify the approach to the problem connected with this disease. He presents a detailed description of the disease. The reading of this book should give the pediatrician, the laryngologist, and the family physician a clearer understanding and thus equip each of them to handle such cases better.

May's Manual of Diseases of the Eye, revised and edited by Charles A. Perera, M. D. ($5.00. Twentieth edition. *Williams and Wilkins, Baltimore, Maryland).* In my student days I studied the seventh edition and now we have the twentieth. It still is in demand the world over as the best manual on the eye.

Intelligence and Personality Factors Associated with Poliomyelitis Among School Children, by E. Larkin Phillips, Isabel R. Berman and Harold B. Hanson, is monograph serial number 45 in volume xii of the Society for Research in Child Development. These workers found a significant difference in these children. They feel that the severity of the disease was more important than the amount of hospitalization and the effects of illness more important than those of treatment in the psycho-social sense.

Diagnosis and Treatment of Brain Tumors and Care of the Neurosurgical Patient, by Ernest Sachs, M. D. ($15.00. Second Edition. *C. V. Mosby Company, St. Louis, Missouri).* Originally written on a demand from the author's students for a text from his pen and revised to date, it stands as one of the best text in its field.

An Atlas of Amputations, by Donald B. Slocum, M. D. ($20.00. *C. V. Mosby Company, St. Louis, Missouri),* planned and written by an orthopedic surgeon who had a large experience with amputees in the war and since. This oldest of the surgical specialities — amputation — has been brought up to date for the civilian surgeon.

Diseases of the Heart, by Charles K. Friedberg, M. D. ($11.50. *W. B. Saunders Company, Philadelphia),* is an integrated and comprehensive exposition of heart disease in all of its aspects in a well-illustrated text of 1080 pages.

An Atlas of the Blood and Bone Marrow, by R. Philip Custer, M. D. ($15.00. *W. B. Saunders Company, Philadelphia)*, contains 285 illustrations with 42 in color. This book summarizes the clinical features of the various blood diseases and calls attention to adjunct laboratory tests so that the blood and marrow pictures can be integrated and too much reliance will not be placed upon the pictures by themselves.

The New Gould Medical Dictionary ($8.50. *Blakiston Company, Philadelphia, Pennsylvania)* is a comprehensive volume with 252 illustrations on 45 plates, 129 in color. It represents the first medical dictionary to be built around a University faculty—our own Western Reserve. Written by 80 contributors, edited by scholars, it marks a new era in dictionary making.

Normal Values in Clinical Medicine, by F. William Sunderman, M. D., and Frederick Boerner, D. V. M. ($14.00. *W. B. Saunders Company, Philadelphia)*. Here is a concept and a book that we have been needing for a long time in medicine. It gives us the range of values which can be accepted as standard—"The Norm"—and so we can tell whether our results fall inside or outside these ranges and are, therefore, normal or abnormal. It is a large volume, as you would expect, of some 838 pages.

Doctor and Patient and the Law, by Louis J. Regan, M. D., LL. B. ($10.00. Second Edition, *C. V. Mosby Company, St. Louis, Missouri)*, has been enlarged through the treatment of at least a dozen new situations and subjects, such as "Adverse Party Called as Witness." All of the original material has been augmented by the addition of relevant decisions of the various courts of jurisdiction. Every physician should read the chapters on malpractice.

Antibiotics, edited by George W. Irving, Jr., Ph. D., and Horace T. Herrick. ($6.75. *Chemical Publishing Company, Inc., Brooklyn, New York)*, has been published under the auspices of the U. S. Department of Agriculture Graduate School and is a collection of lectures presented and sponsored by the School. They have to do largely with the basic facts rather than the details of their use. It makes, therefore, an excellent book of reference.

The Chicago-Cook County Health Survey ($15.00. *Columbia University Press, New York City)*, was conducted under the direction of the U. S. Public Health Service with the help of ten local agencies and some $50,000 of the community's money. Because of its magnitude, this survey represents a landmark in the evolution of cooperative community efforts towards the benefits of a complete and comprehensive attack on the sickness problem of a metropolitan area. It is, therefore, a book which every physician interested at all in the public nature of disease should have access to and should consult. It belongs, therefore, in most public and professional libraries.

Social Medicine: Its Derivations and Objectives, edited by Iago Galdston, M. D. ($2.75. *The Commonwealth Fund, New York City)*, presents the proceedings of the New York Academy of Medicine's Institute on Social Medicine, 1947. Outstanding men with viewpoint from the extreme left to an equal distance on the right have been presented in an orderly and logical fashion to cover this ever-advancing concept that disease is the product of the total environment and so all of the patient in all of his situations must be studied and recognized if we are to escape with more than our skins once our bodies have broken down under the impact of the unfavorable factors in our environment.

Stedman's Medical Dictionary ($8.50. 17th Edition. *Williams & Wilkins Company, Baltimore, Maryland)* has enjoyed a top position for many years. Now for the 16th time it has been revised and brought up to date as a working tool for every physician and his secretary.

The Eye and Its Diseases, by 92 International Authorities, edited by Conrad Berens, M. D. ($16.00. Second edition. *W. B. Saunders Company, Philadelphia)*, contains new chapters on illumination, physiologic chemistry and gonioscopy. Most of the previous chapters have been rewritten and several new faces appear among the contributors.

Clinical Biochemistry, by A. Cantarow, M. D., and Max Trumper, M. D., ($8.00. Fourth Edition. *W. B. Saunders Company, Philadelphia, Pennsylvania)*, as in the previous editions attempts to translate the progress of Science into clinical practice. The text has undergone extensive revision and many additions have been made.

The Hygiene of the Breasts, by Clifford F. Dowkontt, M. D., ($2.50. *Emerson Books, Inc., New York)*, deals with the meanings, purposes, functions and methods of care of the breasts of women. In these modern days, we physicians are apt to overlook the ornamental as well as the functional role of the breasts. The recognition of this is of importance, however, both to the physician and the manufacturer of garments and other intimate devices for improving the care of these organs. All in popular language and with sound advice against self-diagnosis and self-treatment.

Hospital Zone, by Elizabeth Seifert ($2.95. *Dodd, Mead & Company, New York)*, is a novel by the author of **Thus Dr. Mallory** and **Young Dr. Galahad.** It is a love story dedicated to all the heroes of that long battle fought after the war. Good reading!

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JONATHAN FORMAN, M. D., *Editor*

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Acute Appendicitis

C. R. LULENSKI, M. D.

APPENDICITIS is the most frequent disease necessitating a major operation as treatment. In spite of improvements in diagnosis and operative technique and in spite of the advent of chemotherapy and antibiotics, deaths still occur from appendicitis, both in the unoperated and in the operated cases. Some fatalities can be attributed to the tardiness of the patient in coming to the doctor, but many others are avoidable by improving judgment, technique, and supportive therapy. Periodic surveys are valuable to determine if progress is being made. To adequately measure progress, morbidity as well as mortality must be considered.

As an approach to this problem the experience of St. Alexis, a 234-bed hospital, was analyzed for a ten-year period. Trends in treatment were surveyed with an accompanying evaluation of the results. An analysis was made of the immediate postoperative temperature readings on all non-perforated acute appendicitis with a comparison of the ones with buried and the ones with open stumps. To the author's knowledge, no such study has been reported. Conclusions arising from this may clarify the long-standing argument as to whether one should or should not bury the stump. Burying of the stump in these cases was accomplished by chromicized or plain catgut ligature to the base of the appendix followed by amputation. After this the exposed stump was cauterized with phenol and cleansed by alcohol. It was then buried by a seromuscular silk suture applied to the cecum at three-eighths to three-fourths inch from the appendico-cecal junction.

DIAGNOSIS

The diagnoses listed are those found on pathological section, operation or autopsy. Only the acute appendicitis cases have been included in the postoperative temperature analysis. The appendices that are labeled chronic appendicitis, fibrosis of the appendix and "no pathological diagnosis" allow for too many factors and possible other diseases for any proper conclusions to be made. Furthermore, acute appendicitis was considered only if the appendix comprised the primary abdominal pathology. That is, certain acute catarrhal appendicitis and acute appendicitis cases were excluded if the primary final abdominal disease was of another organ. The acute appendicitis cases were subdivided into two classes of non-perforated and two classes of perforated appendicitis; namely, (1) acute appendicitis or acute catarrhal appendicitis in which the inflammation is confined to the mucosa or mucosa and submucosa; (2) acute suppurative, necrotizing or gangrenous appendicitis in which there is diffuse infection, pus and necrosis; (3) acute appendicitis with perforation with abscess formation; and (4) acute appendicitis with perforation with generalized peritonitis.

The study of the diagnostic symptoms and signs revealed the facts of well-established knowledge. However, there were some interesting points that merit attention. In the 1,462 cases of acute appendicitis of all types over 85 per cent were hospitalized in the first attack. A definite number

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Submitted February 24, 1949.

of these patients' first symptom was nausea or nausea and vomiting rather than some type of abdominal distress. This usually was found to be in the acutely obstructive type and signified a fulminating process. Postoperatively, in the drainage cases the fever subsided a few days before the discharge ceased. If the elevated temperature continued in spite of no drainage, it usually meant some complication other than the local disease.

TREATMENT

The treatment given was in accordance with recognized surgical principles. There were many minor variations due to the many surgeons who performed. From 1939 through 1946 many acute suppurative appendicitis cases and the perforated cases were given sulfonamides locally and parenterally. In 1944 through 1946 the parenteral sulfonamides were replaced or supplemented by penicillin. There was much individual variation in the use of drainage and in burying of the appendiceal stump.

Review of the recent literature[1,2,3,4] indicates a McBurney type of incision and burying of the stump are preferred. The question of incision is not in point here because only the hospital stay is being observed. However, from the standpoint of exposure, least contamination of the peritoneal cavity and the later incidence of hernias, a McBurney type of incision is superior to others.

STATISTICAL STUDY

There has been a progressive though irregular decrease in the mortality in the different types of acute appendicitis with an over-all percentage of 2.2 per cent for the ten-year period. For the last five years the mortality is 1.1 per cent. Most of the deaths were in the acute appendicitis with perforation group.

In the acute appendicitis with perforation, of which there were 158 cases, there were 23 deaths or 14 per cent mortality. In the last five years this has been decreased to 10.3 per cent. This table shows there is a progressive lessening in mortality, but in spite of present chemotherapy and antibiotics, the fatalities from the acute appendicitis with perforation group comprise a sizeable percentage. Some of this mortality can be explained on the basis that 65 per cent of all the acute appendicitis with perforation cases did not enter the hospital until over forty-eight hours after the onset of the disease.

Over 85 per cent of all the types of acute appendicitis entered the hospital during the first attack. In the 728 acute appendicitis cases without perforation in the last five years there were four deaths or a mortality of .5 per cent.

During this ten-year study there were 2,758 chronic appendices removed with 14 deaths or a mortality of .5 per cent. These figures compare favorably with statistics reported in the medical literature during the past few years.[1,2,3,4,5] These figures likewise indicate that it is difficult to lower the immediate postoperative mortality significantly below .5 per cent.

TREATMENT OF STUMP

The treatment of the stump was studied in all of the non-perforated acute appendicitis cases. In this series the percentage of stumps buried decreased from 50 per cent in 1937 to 9 per cent in 1946. For the ten-year survey there were 25 per cent buried and 75 per cent left open. In order to ascertain whether or not this was a logical trend, temperature readings postoperatively were analyzed on all of the cases of acute appendicitis without perforation. The temperature taken for the three days after the operation was the highest recorded for each of the successive twenty-four-hour periods. It was believed that the temperature disturbance was the best objective evidence of reaction that was available on all patients. From this survey it was noted that for the first forty-eight hours postoperatively the temperature reaction was on the average .4° lower in the buried instances. In the 12 deaths in the non-perforated acute appendicitis, only two had the stump buried and in one of these the death was proved to be due to pulmonary embolus. Meyer, Requarth and Kozoll[3] indicate a higher incidence of complications in the unburied appendiceal stump cases.

ANALYSIS OF DEATHS

There were 49 deaths all told and 14 were in the group of chronic appendicitis cases. These 14 cases involved eight deaths due to extra-abdominal complications, i.e., five pulmonary embolism, one pneumonia, one pulmonary edema, and one diabetes mellitus. The only buried stump case was the death due to pulmonary edema.

All six remaining deaths were due to peritonitis and in all the stump had been left unburied. There were two autopsies. One postmortem was on a death on the thirteenth day postoperative and showed a cecal fistula at the edge of the stump (probably due to crushing of tissue proximal to the ligature). The other was on a death seventeen days postoperative, and revealed chronic fibrinous peritonitis with many adhesions to the stump. A closed loop obstruction of a segment of small bowel was the immediate cause of death.

In the 1,304 non-perforated acute appendicitis cases there were twelve deaths. Of these there were two due to pneumonia, one to atelectasis, one to pumonary embolism, two to shock (in one case an abdominoperineal resection had also been done with death at thirty-six hours postoperative and the other was at twenty-four hours postoperative with some evidence of internal hemorrhage having occurred). Of the remaining six, five had peritonitis (one of these five also had

pulmonary embolus), and the sixth had intestinal obstruction. There were 3 autopsies in this group of 12 and one was of the peritonitis group showing acute generalized peritonitis with death on second postoperative day. A second autopsy was on a case of pulmonary embolism on the tenth postoperative day. The third autopsy was on the eighth day postoperative and showed a pulmonary embolus as the immediate cause of death but there also was a localized peritonitis at the cecum. The appendiceal stump was open and connected the infected fluid with the inside of the cecum.

There were two deaths in this group in patients with buried stumps. One was on the second postoperative day with the abdomen negative and with X-rays of the chest showing much consolidation. The other was on the fourth postoperative day with evidence of ileus and possible obstruction. Thus in five of the six deaths with peritonitis the stump had not been buried and in the two autopsied cases the unburied stump was the cause of pathology.

In the acute appendicitis with perforation the question of burying the stump does not enter because in the majority no appendectomy was done. In this group there were 23 deaths. Of these there were 20 due to peritonitis and one each due to pulmonary embolism, cardiac failure and cerebral hemorrhage. There were six autopsies in the 20 peritonitis cases corroborating the clinical impression. Thus the percentage of unavoidable catastrophies in this group was small.

DISCUSSION

This analysis of a ten-year experience with operations for acute appendicitis, has been an objective one to decide what policies should be followed in the future to lower the morbidity and mortality. Disturbances in temperature immediately postoperatively, and the causes of death were reviewed in respect to causative factors and particularly referable to whether the stump had been buried. The above information was chosen because it is completely objective and was obtainable on every patient that was surveyed. The specific causes of death are not nearly as objective because there were only 22 per cent autopsies. However, the clinical diagnosis in each death indicated whether or not peritonitis was present. Subsidiary studies were made on the causes of death, particularly on the possibly avoidable causes.

From the physiologic standpoint it appears that the stump of the appendix should be buried in all cases in which there isn't free pus at the cecum. The gastro-intestinal mucosa is diligently peritonealized at every other point and it seems illogical to make an exception of the appendiceal mucosa. Tying the base of the appendix and leaving the stump exposed is definitely more prone to cause difficulty because the autopsied cases reveal cecal fistulas and a higher incidence of deaths due to peritonitis in the open group. There was one instance of unburied stump (using chromic gut) in which on the eighth postoperative day the stump was entirely open. Additional cases showed many adhesions at the open stumps. The contention that the fatty meso-appendix will cover the appendiceal stump is not tenable. It is impossible to cover the stump by tying the meso-appendix to it because the two structures will tend to be side by side. It is necessary to suture-ligate to accomplish a covering protection. If suture-ligature covering of the stump by the meso-appendix is performed then a similar procedure to a cecal pursestring is being employed. To have the least possible local reaction burying should be employed.

The analysis of temperature reactions postoperatively reveals that the unburied stumps cause a higher postoperative fever. Inasmuch as all of the acute non-perforated appendicitis for ten years are included, this is important evidence. It can be stated that the intra-abdominal reaction is greater from an open stump than from the buried type. This is particularly true for the first two days after the operation. On the third postoperative day there is less than .2° difference.

In spite of improved technique and the betterment of the anesthesia plus the antibiotics, chemotherapy etc., the mortality from operated acute non-perforated appendicitis remains .5 per cent. Approximately one-half of these deaths are due to what may be considered as unavoidable complications as cerebral hemorrhage, pulmonary embolism, etc. However, fully one-half of the deaths are possibly avoidable. In some instances the fluid intake and output were not accurately controlled and pulmonary complications were not sufficiently guarded against. In others the amount of antibiotics and/or sulfonamides were not accurately calculated. In many other instances the omission of drainage after soiling of the peritoneum or in the presence of pus, blood or necrotic tissue eventuated in wound abscess and prolonged drainage.

Proper therapy of peritonitis of appendiceal origin is the means by which mortality in appendicitis can be significantly lowered. Prophylaxis is the best treatment and the aim of all good technique is to prevent soiling of the peritoneum. This is most easily accomplished by the prompt removal of the acutely inflamed, intact appendix. A McBurney type of incision should be used and care must be taken to not dissect back the layers of the wound inasmuch as this predisposes to a higher incidence of hematomas, serum pockets and wound infections. The appendiceal stump should be buried by nonabsorbable cecal pursestring with plain catgut ligature to the base. A refinement of this is the

actual inversion of the remnant of the appendix. This may be done by amputation through a crushed portion and inversion of this by a pursestring, or by two layers of over and over Cushing stitch inverting the stump as a hemostat is removed. In each instance care must be observed to include the appendiceal wall at the junction with the meso-appendix to prevent possible later hemorrhage from the small intramuscular artery which is located there in some cases. If omentum is nearby it should be used to cover the cecum. The wound should be closed in layers by oo and ooo chromicized gut. Ordinarily the muscles are not sutured. However, if the internal oblique and/or the transversalis muscles are torn at their fascial attachments, then suturing them at this level is necessary. Early ambulation decreases postoperative distention and ileus.

If peritonitis is present on entrance into the abdomen, the procedure used depends somewhat on the type of fluid and the serosal reaction. If the fluid is thin and there is very little thickening of, or exudate on, the serosa, then appendectomy with burying of the stump should be accomplished with aspiration of all fluid and with no drainage. In the presence of peritonitis as little manipulation as possible should be done. The peritoneum should be developed to cover the walls of the wound to protect them during the operation.

When the peritoneal fluid encountered is thick, grey with necrosis and much exudate, appendectomy without burying of the stump should be performed. The stump should be tied with nonabsorbable ligature. All fluid should be aspirated with drainage placed to the site of origin of the infection, i.e., to and about the cecum. The drain should not be in contact with the open stump nor with any important ligature.

In every case of peritonitis an immediate smear should be made to determine the type of organism(s) present. Culture should also be taken. If the infection is found to be monomicrobic the prognosis is better than if more than one type of bacterium is discovered. The anti-biotics and sulfonamides should be used according to the causative organism present. In the most severe types and in acute peritonitis of unknown etiology (as in unoperated cases) streptomycin 2½ grams, penicillin 1½ million units and sulfadiazine 5 grams should be given daily. Intraperitoneal instillations of these medicines are of no appreciable value and often cause complications. Further treatment should be by the use of a decompression tube and the many supportive measures that are now available.

The various extra-abdominal complications that cause deaths in appendicitis patients must be dealt with by early ambulation, proper assay and therapy of cardiovascular disease, choice of proper anesthetic and the interruption of veins or the use of anti-coagulants as needed.

CONCLUSIONS

1. The great majority of acute appendicitis cases are seen and treated in the first attack. The likelihood of a chronic recurrent appendicitis becoming involved in an acute process is not great.

2. During the past five years the mortality following appendectomy in the non-perforated cases has been lowered to .5 per cent. To lower this further it is necessary to improve care against peritonitis because almost all of the deaths due to intra-abdominal pathology are the result of peritonitis. Maximum therapy as outlined should be available to every peritonitis patient.

3. In spite of the help of improved techniques, antibiotics and chemotherapy the mortality from acute appendicitis with perforation continues to be over 10 per cent. Part of this is traceable to the fact that 65 per cent of these cases entered the hospital more than 48 hours after the onset of definite symptoms. This would indicate the public must be educated to the advisability of obtaining counsel sooner.

4. On the basis of all aspects reviewed it appears that the stump of the appendix should be buried in all instances in which no pus nor thickening is present in the cecal region. Doing this should help in reducing the morbidity and mortality from the non-perforated group.

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Epigastric Pain

With regard to the reflex causes of dyspepsia, when one cannot find an organic lesion in the stomach to account for the epigastric distress, one should make a thorough survey of the other abdominal viscera. In this connection, in patients, particularly more than 40 years of age, one should take an electrocardiogram because not infrequently cardiac pain, or pain due to coronary insufficiency, is referred to the region of the epigastrium.

Finally, if no organic lesion can be found, one is then in a position to begin to think that the patient may be affected with a gastric neurosis or a gastroneurotic functional type of dyspepsia. —A. C. Ivy, M. D., Chicago, Jour. of Missouri State Med. Assn., Vol. 47, No. 1, Jan., 1950.

Sudden Death During Surgical Operations, With Report of Efforts To Revive the Heart

HAROLD FEIL, M. D., and HERMAN K. HELLERSTEIN, M. D.

SUDDEN deaths during surgical operations are sufficiently frequent to warrant considering this problem as a major one in surgery. Sudden death may occur at any time during the anesthesia and the operation. A watchful anesthetist will do much to guide the surgeon when he should permit rest periods or desist from undue trauma or traction. In surgical operations on the heart these warnings are especially important and the surgeon should be aware of any serious deviations from the base line of pulse and respiratory rate, blood pressure, and cardiac rhythm. There are cases—especially young patients, when the induction of anesthesia or the start of an operation will cause sudden cessation of the heart beat and of respiration. The operation may be minor as to trauma or shock, but these cases are the most important ones because the patients are usually otherwise in excellent health.

What is the nature of the cardiac mechanism in sudden death? Experimentally, Harris[1] reported that dogs dying of general anoxia had electrocardiograms showing failure of the pacemaker and slow ventricular rhythm in most instances. Following occlusion of the anterior descending coronary artery, ventricular fibrillation occurred in half of the experiments, cardiac standstill and death occurred in the remaining fifty per cent. In hemorrhagic shock likewise, pacemaker stoppage usually followed, without ventricular fibrillation. Experimental coronary occlusion predisposes to trains of ventricular extrasystoles followed by ventricular fibrillation. Human electrocardiographic observations made during the final minutes and seconds of life[2] show that half of the patients actually die with gradual slowing of the heart and final standstill. The remaining patients have tachycardia, ventricular flutter, and finally ventricular fibrillation. The electrocardiographic recognition of these two modes of death makes appropriate therapy possible.

The operating room should be properly equipped to evaluate the nature of the disturbance of heart action. A direct writing electrocardiograph should be immediately available and suitable drugs should be ready for immediate use (adrenalin, caffeine, ephedrine, procaine hydrochloride (2 per cent solution), injectable quinidine, calcium gluconate, atropine sulfate in ampoules, and an injectable digitalis preparation).

In thirteen cases of cardiac standstill during operation at Lakeside Hospital, the chest was rapidly opened and the heart massaged. In seven cases ventricular fibrillation was present. The fibrillation was stopped by electric shock and the heart was massaged until good vigorous heart action was observed. When the heart was in complete standstill, the heart was massaged until spontaneous contraction occurred. The cerebral and coronary circulations were maintained by rhythmic cardiac massage.

RESULTS

Three patients recovered completely, eight patients recovered good cardiac action with a well-sustained blood pressure but did not recover consciousness and died in twenty-four hours, one died in forty-eight hours, and one died on the operating table. The deaths were due to cerebral failure rather than cardiac failure.

CASE REPORTS

The following are the case summaries of illustrative cases:

Case 1.* Depressed Sternum. The patient, a boy of 14, was being operated upon to relieve extreme sternal depression. While the wound was being closed the heart suddenly stopped. The patient was apparently dead. The wound was reopened and cardiac massage started. Digitalis (Lanatoside C) and epinephrine were given without any effect. The mechanical re-

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Part IV of a Symposium on "Acute Cardiorespiratory Failure: Requirements for Successful Resuscitation," presented at the Annual Meeting of the Ohio State Medical Association, Columbus, April 20, 1949.

* This case was reported previously, Ref. 3.

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spirator was attached to the intratracheal tube and cardiac massage was continued for thirty-five minutes, at the end of which time the electrocardiogram showed ventricular fibrillation. Another record taken ten minutes later likewise showed ventricular fibrillation. The first electric shock did not cause any change in mechansim. Procaine hydrochloride (2 per cent) was injected into the right auricle and the heart was massaged. A second series of electric shock was given, producing complete cardiac standstill. Almost immediately, however, feeble cardiac contractions were observed, and the massage was continued for five minutes more, at which time it was obvious that contractions were coordinated and fairly vigorous, though still fast. An electrocardiogram then showed a supraventricular tachycardia with a rate of 175. From this point on, the heart gradually increased in vigor and brachial sounds were heard at a pressure of 50 mm. of mercury. At no time was cyanosis or pupillary dilatation present. This demonstrated that cardiac massage had maintained an adequate cerebral circulation. After the coordinated heart beat had been established for twenty minutes, the wound in the chest was closed. Within ten minutes after closure of the wound the intratracheal tube was removed and spontaneous respirations were resumed. Within one and one-half hours the blood pressure rose to 60 systolic and 40 diastolic, and thereafter it showed a steady, gradual rise to 100 systolic and 70 diastolic. Three hours after defibrillation of the ventricles, the patient responded rationally to questioning, and by eight hours he was fairly alert in spite of his stormy operative course.

The convalescence for the next few days was chiefly characterized by signs of digitalis intoxication and moderately severe azotemia (nonprotein nitrogen 100 mgm. per 100 cc. of blood on the second postoperative day.) In eight days, however, the patient was much improved, and the BUN was 18 mgm. per 100 cc. of blood.

During the remaining seventeen hospital days, there were no symptoms or signs indicative of injury to the brain and he was discharged on his thirty-first hospital day. In a follow-up interview three months later, the patient stated that he had considerable increase in tolerance of exercise. The electrocardiogram at the time was within normal limits.

* * *

Case 2. Patent Ductus Arteriosus: A child of 4 years was anesthetized. As the areolar tissues at the base of the pericardium were being dissected away the heart stopped suddenly. Inspection of the electrocardiogram showed auricular activity at a rate of 136 per minute with long periods of ventricular standstill (8 sec.) and then complete ventricular standstill for 180 seconds. The heart was massaged after opening the pericardium and adrenalin, 1-1000 solution (1/2 cc.), was applied directly to the epicardium. The auricles continued to beat (at a rate of 100 per minute) and then isolated ventricular beats occurred at long intervals (1.08 to 10.2 sec.). Then followed a ventricular tachycardia (rate 125 per minute) and later at a rate of 250 per minute. Sinus tachycardia followed (214 per minute) and finally the heart slowed to 166 per minute. It was decided not to continue the operation because of the long period of standstill. The child made an excellent recovery with no residual cardiac or cerebral symptoms.

Case 3. Tetralogy of Fallot (with aneurysm of the pulmonary artery distal to the stenosis): This patient, aged 5 years, was explored and the aneurysm exposed. Ventricular tachycardia with a rate of 170 developed. Cardiac standstill, lasting 156 seconds, occurred. The heart was massaged rhythmically and recovery occurred. The Blalock operation was not performed because of the aneurysm. Recovery was complete.

* * *

Case 4. Patent Ductus Arteriosus: A female (aged 27 years) recovered from subacute bacterial endarteritis. During the initial stage of the operation for ligation and section of the ductus arteriosus, the heart suddenly stopped. The electrocardiogram revealed ventricular fibrillation. Cardiac massage and electric defibrillation were instituted. Normal cardiac action with sinus rhythm followed. The patient died twenty-four hours later without regaining consciousness. The postmortem examination revealed cerebral embolism.

* * *

Case 5. Chronic Cardiac Compression (Pick's Disease): Male, aged 26 years. During resection of the pericardium ventricular fibrillation occurred. Cardiac massage, electric defibrillation, and massage were instituted. The patient recovered, was conscious, but died the following day of a communicating pneumothorax.

DISCUSSION

In 1936, Wiggers showed, and Beck emphasized the importance of proper cardiac massage in defibrillation technics. Wiggers showed that failure to recover from ventricular fibrillation depended not so much on the inability to defibrillate the heart as on the incapacity of the myocardium subsequently to resume vigorous beating and because of prolonged cardiac anoxia, apparently, the fibrillating ventricles, deprived of their coronary blood supply for even a short time, lose their capacity for normal excitation and contraction. He suggested, therefore, that cardiac massage (which sustains coronary flow) be started as soon as possible after the onset of fibrillation and be continued until the electrodes are ready for application to the heart.

Sudden death during operations is far from rare. It is imperative that operating rooms be equipped to care for emergencies. The cardiac mechanism must be determined, cardiac massage started promptly, and electric defibrillation must be done when ventricular fibrillation is present. If the heart action is weak, adrenalin, calcium, and continued massage are indicated.

Many lives will be saved, especially in the cases of young patients, who have no intrinsic heart disease, by cooperation of surgeons and internists.

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Propyl and Methyl Thiouracil and Radioactive Iodine In the Treatment of Hyperthyroidism*

E. PERRY McCULLAGH, M. D.

THE three modern methods of treatment of hyperthyroidism are all so good that it is frequently a matter of difficulty to decide which is the method of choice in a given patient.

THYROIDECTOMY: ADVANTAGES AND DISADVANTAGES

Thyroidectomy remains the standard means of treatment in many centers and forms a basis for comparison in estimating the value of the thiourea derivatives and radioactive iodine.

In considering the place of surgery it is well to keep clearly in mind that it must be viewed from two angles. First the goiter itself, and secondly the hyperthyroidism. Surgery is the treatment of choice and is most clearly indicated in patients in whom malignancy is suspected, or when a solitary adenoma exists because of the tendency to malignancy in it, or where the goiter is large and unsightly or causing pressure symptoms. Surgery has the advantage of a quicker complete control of hyperthyroidism than can be accomplished by other methods.

After surgery for hyperthyroidism in adenomatous goiter, not only is the goiter gone, it almost never returns, nor does the hyperthyroidism.[1] In Graves' disease, however, this is not true. It is commonly overlooked that there is a recurrence rate in postoperative Graves' disease which is relatively high. Recurrence rates have been calculated as low as 5 per cent for all types of goiter[2] and as high as nearly 20 per cent in Graves' disease.[3]

Surgery for hyperthyroidism has become very safe. This is due chiefly to the complete preoperative control of the disease with propyl or methyl thiouracil and to the fact that other methods of treatment are available to patients who for one reason or another are never good surgical risks. The mortality rate of surgery is a small fraction of 1 per cent[1, 4] but even this is higher than the mortality rate of other methods. Surgery has the disadvantages of the need for hospitalization, the discomfort and the cost of the operation, as well as certain complications the chief of which are laryngeal paralysis, tetany and hypothyroidism.

Postoperative laryngeal paralysis varies from about 0.5 per cent in good hands in once operated patients to as high as 7 per cent or more in less expert hands and especially in patients operated upon a second or third time. The frequency of tetany follows a similar pattern and postoperative hypothyroidism rises in frequency from 10 per cent to nearly 20 per cent where the cure rate of Graves' disease is very high. During pregnancy thyroidectomy after proper preparation is well tolerated but surgery is never indicated in hyperthyroid crisis.

PROPYL AND METHYL THIOURACIL

Propyl thiouracil has been adequately shown to be safe and effective as a means of controlling any hyperthyroidism.[5] Its action like other thiourea compounds is to block the production of thyroid hormone within the thyroid thus producing a physiologic thyroidectomy.

The dose required varies with the individual. A higher dose is needed in nodular goiter than in diffuse, and a higher dose in severe hyperthyroidism and in large goiters than in mild hyperthyroidism associated with small glands. In general 300 mg. per day is effective in 96 per cent of patients.[6] In severe cases 400 mg. may be needed. Since each dose lasts only a few hours the doses should be spaced at intervals of about six hours. Methyl thiouracil, though dangerous in the large doses originally used in Denmark and Sweden, has a safety closely comparable to propyl thiouracil in similar doses and has a somewhat more powerful and quicker effect.

If iodine has been used in treatment before propyl thiouracil is begun it should not be withdrawn abruptly, for if it is, a sharp exacerbation of the disease will occur before the full effect of the thiouracil is present. A small dose of iodine can be given concurrently, it is practical to use approximately 10 mg. of iodine per day as 1 drop of Lugol's solution or a tablet. This prevents

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the increased vascularity of the thyroid which otherwise commonly occurs. In these doses iodine does not prevent the effect of the propyl thiouracil.

Propyl or methyl thiouracil are most clearly indicated for preoperative preparation especially in severely ill patients. It may be used as continuous therapy where necessary in patients whose operative risk never becomes good. It is the treatment of choice for postoperative recurrent hyperthyroidism when radioactive iodine is not available. It may be used in an attempt to produce a permanent cure and although final statistics are not available the chances of cure seem best in patients who have relatively small goiters and in whom the hyperthyroidism is not very severe.

It is less promising in those instances in which the goiter tends to enlarge under treatment, or when the patient is less than twenty years of age. In spite of these generalizations, 11 of the first 50 of our patients now in remission had metabolic rates over +50 per cent and some had large nodular goiters. In our first 218 patients treated, the dose was sometimes inadequate by present standards and the patients unselected. Remissions known to have lasted over six months occurred in approximately 50 per cent. It seems reasonable to believe that in properly selected cases cures will be produced in more than 60 per cent. This is approximately the same estimate as that made by Williams[7] for thiouracil.

The plan of treatment now in use involves maintenance of complete control of the hyperthyroidism for one year before withdrawal of the drug. If hypothyroidism occurs it is often better to treat it with thyroid than to run the risk of lowering the dose of antithyroid drug to an ineffective level.

Propyl or methyl thiouracil can be used to control hyperthyroidism throughout pregnancy but there is a risk of producing goiter in the infant. This risk is obviously greater if relative hypothyroidism is produced in the mother. Therefore if surgery seems ill advised and it is too late in pregnancy to avoid uptake of I^{131} by the fetal thyroid, the dose of antithyroid drug should be manipulated in such a way as to allow a normal rise of metabolic rate in the mother toward the end of pregnancy or even to allow a mild hyperthyroidism to exist.

Disadvantages of propyl or methyl thiouracil include the following:

1. The goiter is not removed.
2. The goiter sometimes enlarges, though it is usually smaller at the end of prolonged therapy.
3. The recurrence rate is higher than that following the other methods of treatment.
4. Toxic symptoms necessitate discontinuance of treatment in about 2 per cent.
5. Agranulocytosis has been reported as a cause of death in rare instances.
6. It should never be depended upon as therapy in a crisis.

In over 400 patients I have seen severe toxic symptoms in only two. These were exfoliative dermatitis and a drug eruption. It is unnecessary to do routine blood counts but the patient should be warned that a fever or sore throat (which may indicate agranulocytosis) should be reported promptly.

If the white cell count falls to 2000 or the granulocytes to below 25 per cent the drug should be stopped. Death due to agranulocytosis can probably only properly be ascribed to propyl thiouracil in four patients. Of the many thousands treated, this is a mortality rate of a fraction of a tenth of 1 per cent.

The great advantages of propyl or methyl thiouracil therapy are that they allow avoidance of hospitalization, cost of surgery and apart from occasional toxic effects there are no complications and none which are lasting. A patient receiving a cure from these drugs has a completely physiologic cure.

RADIOACTIVE IODINE

I^{131} is peculiarly adapted for the treatment of hyperthyroidism by a happy group of circumstances. (1) Because of the avidity of hyperactive thyroid epithelium for iodine, I^{131} can be concentrated in the thyroid about 10,000 times more than elsewhere in the body. (2) Because of its short half-life of eight days most of the administered dose remains within the thyroid until its energy is largely dissipated. (3) A high effective dose of irradiation can thus be applied from within the gland. (4) The Beta rays it emits penetrate only 1 or 2 mm. thus rendering no damage to surrounding tissue.

Of the hundreds of patients now treated, no damage has been known to come to the blood, the kidneys, bladder, bone marrow, reproductive organs or the tissue surrounding the thyroid. Hertz[8] has mentioned 16 normal babies born from parents treated with I^{131}—11 mothers and three fathers. There has been no evidence that it causes cancer and in about 10 per cent of patients with cancer of the thyroid I^{131} in large and repeated doses has been beneficial.

Although it is now twelve years since Hertz[9] began his study of radioactive iodine tracer doses, no entirely satisfactory method has been arrived at to estimate the required therapeutic dose needed by a given patient. In general it is true that in the diffuse gland of Graves' disease the effective dose is relatively small. Here it appears to vary chiefly with the size of the gland and the severity of the hyperthyroidism. In practice it is very important to separate the hyperthyroidism of Graves' disease

from the hyperthyroidism of nodular goiter, because a curative dose in a large nodular goiter may be more than ten times as large as that required for a small diffuse gland.

The required dose can be estimated to some degree by measuring the ability of the gland to take up a tracer dose[10, 11] which may be 100 to 400 microcuries. The uptake may be influenced greatly by factors other than those mentioned, especially the previous use of iodine, which if used in large doses will inhibit the uptake of I^{131} for three or more weeks after it is stopped and some blockage may be affected by the inadvertent use of iodine as in cough mixtures, iodized salt or iodine-containing contrast media for X-ray diagnosis. There is also a blockage produced by the thioureas but this disappears in three or four days after the drug is stopped.

A very practical method of estimating the proper dose is to observe the physiologic effects of a safe initial dose. For example: in Graves' disease, in a gland estimated to weigh 60 gm. and with an I^{131} tracer uptake of over 60 per cent, 4 mc. has proved to be a safe dose (Oak Ridge standard).* In larger glands 6 or even 8 mc. may be used. If no improvement is evident in two months the dose may be safely repeated. If on the other hand the basal metabolism has fallen to near normal and improvement continues in two months, more time is allowed before another dose is given.

Other methods of estimation of the required therapeutic dose of I^{131} in Graves' disease have been published. Haines and his co-workers[13] estimate the uptake of a tracer dose, compute the mass of thyroid tissue present by palpation and calculate a total dose which will supply between 200 and 250 microcuries per gram of thyroid.

In nodular goiter an initial dose of 8 to 15 mc. may safely be given and cures may require doses as high as 58 mc. in our experience.

Within the past year we have treated 105 patients with I^{131}. Twenty-eight patients have been followed long enough to warrant an opinion as to results. Nineteen of these had Graves' disease and four to ten months have elapsed from the time of treatment to the time of this survey. All were cured. The total doses varied from 3 to 15 mc., an average of 6.7. Twelve patients had one treatment, 6 had two and 1 three. The average estimated weight of the gland before therapy was 61 gm., after therapy 27 gm. Two developed hypothyroidism. Mild exacerbation of hyperthyroidism and mild irradiation sickness have been reported immediately following treatment. No other complications except hypothyroidism have been seen following this treatment by us or others.

In nine patients with nodular goiter the hyperthyroidism has been controlled and the goiters are smaller. The total doses required were 12 to 58 mc. Two had two treatments, 5 had three, 1 had four, and 1 had six. The estimated weight of the goiters averaged 116 gm. before and 57 gm. after treatment.

I^{131} can be used safely during pregnancy only before the fourth month, since Chapman[12] has shown that there is a perceptible uptake by the fetal thyroid after that time. When I^{131} is available it can be used in the treatment of crisis—not as complete therapy but followed promptly by iodine medication as usual. There is some loss of I^{131} under these circumstances.

The tremendous advantage to the patient with this type of therapy is evident. It is taken as a drink of water. Little or no medical supervision and no hospitalization or work loss are necessary. There are no untoward side effects worthy of mention and apart from hypothyroidism no complications. Hypothyroidism has been present in about 10 per cent. Disadvantages lie in the fact that treatment is not available to all patients and the material to date can only be handled by groups of men with special skills acceptable to the Atomic Commission.

The cost is not known since the true cost of production of the material is not calculated. This treatment up to the present is reserved chiefly for those individuals over 40 years of age until enough time elapses for greater certainty with respect to possible late complications which are not expected.

* Present standards are 1.75 times greater than those used at the time this article was written. Thus, a dose previously designated as 4 becomes 7 and a dose previously designated as 8 becomes 14.

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The Interpretation of Psychosomatic Complaints To the Patient

BLAKE CRIDER, Ph.D., and ROBERT SCHOTT, M.D.

PHYSICIANS are aware of the fact that a considerable portion of their professional time is being devoted to the practice of medical psychology, which is the diagnosis and treatment of patients who have physical complaints arising from emotional upsets. Malamud[1] states:

"It may be said without fear of exaggeration that the number of people whose adjustment is interfered with because of the various forms of psychoneurotic disturbances is greater than that found in any other single type of medical disease known to the profession. A well-known and reliable specialist in internal medicine, who was, at that time, director of one of the largest general hospitals in the country, estimated that of the entire clientele of the outpatient department of his institution computed over one year, fully 75 per cent were suffering either from pure psychoneurotic syndromes or psychoneurotic superimpositions upon somatic diseases. Even if this may be an unusual proportion of the incidence of these disorders, other men working in the field and equipped with the training and interest enabling them to evaluate their material properly have varied in this estimate from a conservative 40 per cent to the high 75 per cent mentioned above."

The physician is daily confronted with patients having a multitude of somatic complaints for which he can find no organic basis.

If the physician tells the psychosomatic patient, "It is your nerves," the patient rightfully assumes he has some organic disability and expects to be given medicine. If he tells him he is neurotic, he is likely to be offended. If he is told he has a neurosis, the patient may equate neurosis with psychosis and conclude that he is insane. To tell the patient there is nothing wrong with him merely confuses him because obviously there is something wrong. What the physician should do is show the patient how his somatic complaints can arise from emotional upsets. This explanation is the first step in therapy.

Physicians who are unable to handle the psychosomatic patient constructively are inclined to blame the patient for not wanting to get well. And to a considerable extent they are right about the patient, for he does seem to resist treatment. This negative attitude on the part of the patient was succintly described in a recent article by Dr. Andrew Hart of the University of Virginia Medical School, wherein he listed fifteen ways in which the psychosomatic patient attempted to sabotage his treatment.[2] We are unable to cover in this article the entire psychology of resistance, but we can give the physician a technique for overcoming the patient's resistance to a psychological interpretation of his somatic distress; one which he can use beneficially in his daily practice.

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The two basic emotions which result in somatic complaints are anger and fear, with jealousy, envy, hostility, anxiety, and feelings of guilt coming under one or the other of these two major emotions.

When a person has anger or fear, all of the organs of the body mediated by the autonomic nervous system are to some extent activated. Sensations from these organs go to the brain and are perceived in consciousness as pain or discomfort. The person feels his heart beating faster, realizes his temperature goes up, that he is sweating profusely, reports that he has "butterflies" in his stomach, and so on.

If these visceral sensations occur from an acceptable and recognizable emotionally arousing situation, the individual accepts them as normal and would find no reason to seek medical advice. For example, if a person is caught in a falling elevator he is naturally afraid, and thus receives unpleasant sensations from his viscera; nevertheless, he makes the best adjustment he can. However, a person may have these identical visceral sensations and yet may not be able to identify in his conscious and perceptual environment the reason for these peculiar body sensations. He does not recognize them as fear, anger, or hostility but thinks of them solely in terms of their somatic language; he thinks he

has an illness. This conclusion that he has an illness makes the patient afraid, and this fear exaggerates the very symptoms which frightened him in the first place.

Emotions and their accompanying visceral sensations, which have no apparent justification to the patient, arise from repressed impulses or mental conflicts. The impulse is repressed because it is unacceptable to the person's ideals and standards, or to his ego and super-ego, if we wish to be more technical. But once the impulse is repressed, it may continue its arousal of hostility, guilt, and anxiety just as it did while in conscious awareness. The distressed individual has his body sensations, but he does not know why, i.e., the cause is unconscious. This unconscious element is the factor which makes an emotional disturbance a neurosis.

At this point the person may take any one of several psychological paths. However, the decision most likely to lead him to a physician would be his belief that he is genuinely ill. Then the emotionally distressed individual goes to the physician complaining of indigestion, constipation, loss of appetite, profuse sweating, difficulty in getting his breath, and so on. He believes he has an illness, that the physician will find a cause for the illness, will prescribe medicine, and that he will get well.

The physician must explain how these body sensations are possible without the patient being genuinely ill, yet make the explanation in such a way that the patient will accept it. This should be done even though the patient is to be referred. In many cases, however, this explanation alone is sufficient therapy.

We have worked out a technique for interpreting to the patient the emotional basis of his complaints. This technique we wish to pass on to the general practitioner because we feel it is something he can use routinely and constructively in his practice.

We should point out, however, that this technique applies primarily to the patient who is emotionally upset because of situations operating somewhat currently, and that it is not applicable to the classic textbook cases of neurasthenia, hypochondrias, conversion hysteria, and the obsessive-compulsive reaction patterns. This leaves those persons suffering from the anxiety states, constituting the bulk of the physician's psychoneurotic patients.

Once the physician decides that the somatic complaints arise from emotional upsets activated by unconscious impulses or conflicts, the following steps are taken in explaining the diagnosis to the patient:

1. Have the patient list all of his complaints. Write these complaints in a column.

2. Go back over the various organs and make inquiry concerning those organs where the patient omitted any symptoms. For example, "Does your heart sometimes beat rapidly?" This helps complete the list of symptoms.

3. Now ask the patient how he would feel were he afraid (or angry). List these characteristics in a second column beside the first column. You may have to encourage him by saying something like this: "Wouldn't you have 'butterflies' in your stomach too?"

4. Show the patient that the sensations that go with emotions of anger and fear are the same as his complaints. Point to them with a pencil to show how they match. For example, he may have come with the complaint that he has trouble getting his breath, and that when he is angry he has the same difficulty.

5. Then ask him to tell what is really keeping him upset or emotionally disturbed and what he is worried about.

6. Make a final summary and interpretation for the patient.

This procedure is illustrated in the following two cases. The interviews were short and were recorded verbatim. Other patients may require longer interviews or several interviews before understanding occurs. But we have selected two dispensary patients of dull mentality from unfavorable socio-economic backgrounds to show how understanding can occur to even the less favorably endowed psychosomatic patient.

CASE REPORTS

Case 1: The patient was a 37-year-old Negro male who complained of nervousness. The medical examination was negative.

1. Get the patient's complaints.

Therapist: What's bothering you?
Patient: I've got an irritation in the stomach. I got a funny feeling in my stomach. I get weak in the legs. I have hot flashes too.
T. Anything else?
P. That's about all.

2. Make further inquiry.

T. What about your heart? Doesn't that beat fast too?
P. Yeah—like it was scared. Noise gets me too. I wonder what it could be. I never feel good. Just sluggish all the time.
T. Doesn't your bladder bother you too; don't you have to go to the toilet pretty often?
P. Sometimes I can't control it. I just have to rush to make it.
T. And at night, what happens?
P. It's O.K. Sometimes I do have to get up and I have to go quick.
T. And how's your appetite?
P. It's poor.
T. How do you sleep?
P. It was bad until I took some pills.
T. Don't you have sweats sometimes?
P. I used to have them before I went to the doctor.
T. I imagine your throat gets dry sometimes too.
P. Yes, it does. I have to clear it up.
T. Do you ever have trouble getting your breath?
P. No, I don't.

T. I guess you have headaches sometimes.
P. Oh, I do. I had one the other day. But I thought it was because I got hit in the head once.

3. Get a list of emotional characteristics.

T. Just how would you feel if I socked you in the jaw?
P. I'd get upset, it would get me all over.
T. Would your heart beat fast?
P. Yes, it would; like it was scared.
T. Wouldn't your stomach feel funny?
P. Yeah, a cutting feeling.
T. Wouldn't you have trouble getting your breath?
P. I couldn't get out what I wanted to say.
T. Don't you have to urinate when you are embarassed or talk to a group of people?
P. Yeah, it does irritate me.

4. Show the relationship.

T. You see, all these funny feelings you get when you are angry or scared are the same as those you say bother you now.
P. Yeah, I see.

5. Ask patient for explanation of his emotional state.

T. Can you see what's bothering you? What's really bothering you and making you sick is the job isn't it? And we will have to figure out what is wrong about it that makes it get you so upset.
P. I don't know. Maybe they expect too much of me out there. They hired me as a welder. Now I am a flunky. I had to clean up the office the other day. They promised me a raise and I never got it. They put another man in my job. They put me to doing janitor work. Everybody was saying, "Hurry, hurry." They put me to driving a truck. I told them I didn't have a driver's license. I didn't even know how to drive a truck. They said I didn't want to work.

6. Final summary and interpretation.

T. So you see you have two things. You were scared and you were angry. You felt you got a raw deal. You got upset. You felt it inside and that's what you called your nerves. It is really an emotion. This has been going on now for a whole year, and it makes you tired and you can't sleep. You get all jumpy inside. They won't even believe you are sick, and that makes you even madder. But you are sick, but because of your emotions. If you got along on the job better or if you had another job, you would be in good shape.
P. I can get a better job.

* * *

Case 2: The patient was a 30-year-old white woman. Medical examinations were negative.

1. Get the patient's complaints.

T. What is your trouble?
P. I have a numbness in my head. My hands sweat and then they get cold. My stomach bothers me. My eyes get sore. I am weak in the legs. I am afraid to go places.
T. Is there anything else?
P. I guess that's about all.

2. Make further inquiry.

T. Does your heart ever beat fast?
P. It sure does.
T. Does your mouth ever get dry?
P. A lot of times when I am nervous.
T. Do you have to go to the toilet often?
P. It does bother my kidneys. My bowels are awful. I am always constipated.
T. Do you ever have headaches?
P. I get them frequently. I have a lot of pains in my neck, too.
T. What about your breathing?
P. I can hardly get my breath sometimes.

3. Get a list of emotional characteristics.

T. What do you think caused this condition?
P. It might be my teeth. I had some of my teeth out. Perhaps it is change of life. But I am a little young for that.
T. What if someone walked in suddenly and threatened to kill you? How would you feel?
P. I'd be scared. I'd tremble and shake.
T. Would your stomach get upset?
P. It sure would.
T. Would you be weak in the legs?
P. Yeah.
T. Would your heart beat fast too?
P. Sure would.
T. Would your mouth get dry?
P. Sure would.

4. Show the relationship.

T. Just what do you make out of what you have just told me?
P. You are just trying to find out what is wrong.
T. Here is what it means. You notice that the complaints you gave to me about your health are just the ones you would have if someone threatened to kill you and got you real scared.
P. They are just the same.
T. What you have is just fear. It is not a sickness, and it is not your nerves.
P. That may be right.
T. Then we have to find the cause of that fear.
P. I guess we do.
T. What troubles you? What have you worried about? You just tell me what it is.
P. It's because there is something wrong with me physically.
T. Just a fear of being sick.
P. Yeah, just a fear of being sick and going any place.
T. It is really a fear of a fear.
P. Yeah.
T. You had a fear and it got you upset and then you got afraid of that upset because you thought it was an illness.
P. I won't go to shows or nothing. I was even afraid to come to the hospital.
T. But we want to know just how it started the first time. Let's find out what is really troubling you.
P. (Here patient relates that two years previously she had noticed an irritation on the external labia. She went to a physician who made a tentative diagnosis of syphilis, with subsequent negative Wassermann. This frightened the patient. She began to read "Doctor Books." The more she read the more frightened she became until she was filled with somatic complaints on an emotional basis).

SUMMARY

We have outlined a technique for interpreting to the patient the meaning of physiological symptoms arising from emotional upsets. We consider this the first step in therapy, regardless of whether the physician himself does the therapy or refers the patient to specialists in psychotherapy and medical psychology.

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Treatment of Acute Leukemia of Childhood*

ROBERT W. HEINLE, M. D.

THE FOLIC acid antagonists have made it possible to prolong the lives of certain patients with acute leukemia beyond any duration possible before. Their use was inaugurated after it was discovered that acute leukemia in children[1] and chronic myeloid leukemia in adults[2] were aggravated by the administration of folic (pteroylglutamic) acid.

The folic acid antagonists are compounds chemically very similar to folic acid. Thus, aminopterin (4-amino-pteroylglutamic acid) has an amino-group (NH_2) in place of a hydroxyl-group (OH) of folic acid. A-methopterin (4-amino-N^{10}-methyl pteroylglutamic acid) has a similarly substituted amino-group in addition to which a methyl-group (CH_3) replaces one hydrogen atom of folic acid. Several other antagonists have been synthesized and have varying degrees of effectiveness.

Folic acid is necessary for the proper growth of leukocytes, as well as in the metabolism of many, if not all, other cells of the body. The antagonists act by competing with folic acid in the metabolism of the cells. The action is comparable to that of the sulfonamide drugs in which para-aminobenzoic acid, necessary for the growth of certain bacteria, is displaced by the chemically similar antagonist. Since folic acid is probably necessary in the metabolism of most cells, it might be expected that a folic acid deficiency induced by the use of the antagonists would affect all cells equally. That it does not is probably due to the fact that the abnormal cells of certain acute leukemias are metabolizing very much more rapidly than normal cells, their folic acid requirement is greater, their uptake of the antagonist is greater, and a folic acid deficiency is induced in them before it becomes apparent in normal cells. Thus, a semi-specific effect can be obtained, at least for varying temporary periods of time.

Twenty-six children with acute leukemia, 6 adults with acute monocytic and 2 with acute lymphoid leukemia have been treated with the folic acid antagonists at University Hospitals of Cleveland.† In addition, two adults with chronic myeloid leukemia have been treated with a crude, weak antagonist in association with a folic acid deficient diet.[2]

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RESULTS OF TREATMENT

Of the 26 children, three died within less than two weeks after therapy was instituted, and these are excluded from the series, since the duration of life was not sufficient for the drug to be given an adequate trial.

Eleven of the remaining 23 are still alive, and 12 have died. The longest remission lasted ten months, in a patient still under observation, and the shortest one and one-half months. The latter patient, however, had acute monocytic leukemia rather than the more common small cell leukemia of the other cases. All of these cases had some improvement after antagonist therapy. In five, symptomatic improvement without objective blood or bone marrow improvement occurred. These five experienced a sense of well-being, and an increase in appetite, which lasted for varying periods of time.

Eighteen of the 23 had both hematologic and symptomatic improvement. In the most complete remissions, the peripheral blood and bone marrow returned to so nearly a normal state that little evidence of leukemia could be demonstrated. Spleen and lymph nodes decreased in size or returned to normal. Bone pain, common because of the marked involvement with leukemia, completely disappeared and children who had stopped walking because it was painful walked again without pain.

This happy state of affairs lasted only three to four months on the average, however, at which time relapse ensued. While many of the patients obtained another remission upon resuming or increasing the dose of antagonist, the remission did not occur as quickly and was never as complete as with the first course of treatment.

AUTOPSY FINDINGS

Of the 12 children who died after having had various degrees of remission, autopsy findings

* This study was aided in part by a grant from the National Vitamin Foundation. The aminopterin, A-methopterin and crude antagonist were generously supplied by the Lederle Laboratories Division, American Cyanamid Corp., through the courtesy of Dr. Thomas H. Jukes.

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† All but two of the children reported in this series were cared for at the Babies' and Children's Hospital, Cleveland, Ohio, Dr. Charles F. McKhann, Director. The diagnosis and treatment were under the immediate direction of Dr. Eugene Weber and Felix E. Karpinski, who will report these cases in more detail in a later publication.

are available in nine. In one case, reticulum cell sarcoma was found, although blood and bone marrow findings during life were typical of acute leukemia. Of considerable interest is the fact that in the other eight cases, little or no evidence of leukemia was present at autopsy. The bone marrow tended to be hypoplastic in all these cases, but complete aplasia was present in none. In one patient, marked ulceration was present in one localized area of the jejunum but generalized intestinal ulceration was not encountered.

The cause of death was doubtful in these cases. In three, terminal hemorrhage and severe anemia could certainly have been responsible for death. In the remainder no obvious cause was present. The patients usually lost their appetites, slowly lost weight and strength, became unconscious after varying periods of time, and died, much as a terminal case of cancer may die.

ADULT LEUKEMIA

In none of the eight cases of acute leukemia in adults was there any evidence of clinical or hematologic improvement. Similar cases have sometimes shown some improvement in the experience of others,[3 4] however.

Both cases of chronic myeloid leukemia treated with a crude antagonist and a folic acid deficient diet, obtained clinical and hematologic remission. The effectiveness of the antagonists in chronic myeloid leukemia does not compare with that of radiation therapy, however, and it seems safe to state that the folic acid antagonists have no place in the treatment of chronic myeloid leukemia. In chronic lymphoid leukemia, there may be substantial reduction in the number of circulating lymphocytes but the effects of the antagonist are manifested predominantly by a reduction in granulocytes and platelets.[5] This occurrence can probably be explained on the basis that the more mature lymphocyte of chronic lymphoid leukemia may not have as rapid a metabolism as the granulocytes and platelet precursors, and so are not as susceptible to interference with the folic acid mechanism as are the normal bone marrow elements.

DOSAGE

The dose schedule of the folic acid antagonists probably cannot be computed on a patient-weight basis. In children, the dose of aminopterin is 0.5 to 1.0 mg. daily and the author believes that larger doses are more toxic without being more effective. In adults, similarly, doses larger than 1.0 mg. daily have led to rapid production of toxicity. A-methopterin can be given in doses three to five times as great as that of aminopterin. Other antagonists can be given in larger doses.[1] Thus far, however, toxicity and effectiveness have run parallel, and an effective dose of any of the antagonists may be associated with toxicity.

Our cases were treated with daily intramuscular doses until a desirable effect was manifest, usually within two to three weeks, or until toxic manifestations occurred. When a remission was induced, the patients were given an intramuscular dose three times a week unless toxic manifestations occurred, in which event treatment was temporarily interrupted. When relapse occurred, daily injections were resumed. It has been our experience that when relapse occurs, response to increased dosage of the antagonists is not as good as with the first course of treatment.

TOXICITY

Toxicity is manifested principally by ulceration of the mucous membranes of the gastro-intestinal tract. Ulcers develop on the lips and in the mouth, and, with the exception of the stomach, throughout the gastro-intestinal tract. This is usually associated with bloody diarrhea. Alopecia has been reported by others[6] but has not occurred in our series.

The folic acid antagonists can produce complete aplasia of the marrow if the dose is not controlled. It is probable that some hypoplasia always precedes the hematologic improvement even in those patients deriving the most benefit. For this reason, the blood should be examined three times a week and frequent marrow examinations must be made when the patient is under active treatment.

As soon as any toxic lesion becomes manifest, the drug should be discontinued until improvement occurs, usually within seven to ten days. Folic acid may be administered although it has not been necessary in our patients and its benefit is doubtful. Liver extracts, previously given with the antagonist to prevent toxicity, are no longer used because they have proved of no value in our patients or in the experience of others.[1, 3]

SUPPORTIVE TREATMENT

It must be emphasized that repeated blood transfusions and use of the antibiotic drugs, principally penicillin, remain a very essential part of the treatment of acute leukemia. Blood transfusions relieve the symptoms of anemia and, to a certain extent, control the bleeding. Penicillin certainly has prolonged life by preventing death from infection to which these patients are so susceptible.

Hemmorrhage is a common and serious complication of acute leukemia. The use of the heparin-neutralizing drugs, protamine sulfate and toluidine blue, have been recommended[7] but in our cases these substances have proven to be of no value when used in doses of 2 to 3.5 mg. per kg. of body weight. This does not surprise us, since hyperheparinemia cannot be demonstrated

in these patients, and in all probability the bleeding is due to the thrombocytopenia and associated abnormal capillary permeability.

DISCUSSION

The folic acid antagonists have made it possible to prolong the life of many children with acute leukemia. In general, the extra months are comfortable and reasonably happy ones, with marked clinical and hematologic remission. Relapse invariably ensues, however, and all the patients eventually die. At autopsy, very little evidence of leukemia may be found and the exact cause of death may not be evident. It seems likely that a general folic acid deficiency may have occurred in these patients and is the cause of death.

The folic acid antagonists are not a satisfactory form of treatment, therefore. In the opinion of the author, their ultimate failure is due to the fact that derangement of the folic acid mechanism is not the primary biochemical abnormality in leukemia. While it is possible to interfere with this fundamental cellular biochemical process, the attack is not made on the primary defect. It can be hoped, however, that a more fundamental defect can be found, and an effective means of treatment devised.

SUMMARY

1. Marked remissions with prolongation of life can be attained by the use of the folic acid antagonists in acute leukemia of childhood.

2. In our experience, acute leukemia in adults has been entirely refractory, although others have reported beneficial effects in some cases.

3. The antagonists are extremely toxic and can cause death unless administration is carefully controlled.

4. The use of blood transfusions and penicillin constitutes an important part of the treatment of acute leukemia.

5. The anti-heparin compounds, protamine sulfate and toluidine blue were ineffective in combating the hemorrhagic tendency in these cases.

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KEEPING UP WITH MEDICINE

• YOU may well raise the question whether old age has any diseases of its own.

* * *

• DENTISTS sometime have to take out teeth because the supporting structures are inadequate. Here is where nutrient needs first play an important role in preventive medicine.

* * *

• THE use of arsenic (Fowler's solution) is a safe and reliable method of treating polycythemia. The real objection to its use is the loss of appetite, nausea, and vomiting which so commonly occur and turn the patient against the drug.

* * *

• IN the pregnant diabetic, high fetal mortality, pre-eclampsia and obstetrical abnormalities parallel an abnormal pattern of sex hormones.

* * *

• STUDY of the spinal fluid and measurements of the cerebrospinal fluid pressure during the first few hours after an injury to the head almost never provide information of real help.

* * *

• THE practice of anesthesiology demands a thorough grounding in the physiology and pharmacology of circulation and respiration, combined with proper training in clinical medicine. The basic training is only "refresher work" but training in clinical medicine—that is different.

* * *

• THEY are looking for tuberculosis vaccine which will produce a high level of allergy and relatively few complications.

* * *

• IT has been recognized for nearly twenty years now that chick eggs, unlike hen eggs, may actually contain pathogenic organisms of the *Salmonella* group.

* * *

• INSTANCES of death from dermatitis and stomatitis during streptomycin therapy should keep us on our guard against hypersensitiveness.

* * *

• ANTIHISTAMINES are reported as successful in the treatment of nausea and vomiting of pregnancy. Wonder if the huckers will seize upon this.

* * *

• WE should not forget allergy to denture material when seeking for the cause of angular stomatitis—especially in those persons who keep the dentures in all night.

* * *

• UNDULANT fever sometimes gives us a generalized lymphadenopathy which may closely simulate glandular fever of Hodgkin's Disease. —J. F.

Elective Surgery In Infancy

HENRY W. LEHRER, M. D., HENRY G. LEHRER, M. D., and DAVID R. LEHRER, M. D.

WITH the present concepts of medicine and surgery today, it is time to re-evaluate surgery in infancy. This surgery is that which cannot be truly termed emergency surgery. Many times it is health-saving and on some occasions it is actually life-saving, but it is not truly emergency surgery. So we will, from the beginning, rule out the acute appendicitis, intussusception, congenital pyloric stenosis, and the various congenital anomalies that produce symptoms so early in life. In this elective surgery in children we must remember that there are several important things to consider. First, we must remember that we are operating upon infants, not upon "young adults." They are entirely different persons and an entirely different problem and it is upon this basis that the specialty of pediatrics is founded.

Infants stand surgery surprisingly well. It is true they do not withstand adult surgery, but if the surgery is adapted to the child and the procedure is kept as short as possible, as simple as possible, and done with the dispatch that comes with confidence in knowing what you are doing and with the gentleness that is likewise present, the response of children to surgery is most gratifying. This means that in the actual surgery meticulousness and gentleness with all tissues must be practiced and instruments used that are designed for infants, not the big clumsy snaps that we use on adults. We must realize, however, that in children, their reactions to trauma are generally more severe. For instance, their metabolism is much more active than an adult's. Their chemistry is more unstable and the margin of safety is much more narrow. The surgery should be done as quickly as is consistent with careful handling of tissues and complete hemostasis. Speed should never be secured at the expense of hurried, careless work. We must remember that children do not stand shock well because of their narrower water ballance threshold. Fluid shift from the bloodstream is not at all tolerated. Hemorrhage is poorly borne. Extreme care in limiting blood loss must be practiced as a loss of 25 cc. of blood in an infant is equivalent to the loss of 500 cc. in an adult.

FLUID BALANCE

In the question of fluid balance, it must be remembered that a child weighing about nine pounds requires at least 600 cc. of fluid a day preoperatively. There is no reason why, if the child cannot take this orally, that he cannot be given fluids subcutaneously or, if necessary, by continuous intravenous drip. A canula can be put in one of the arm or leg veins and blood can be given in this manner also, if it is necessary. The arm is usually better to use as it can be more easily immobilized than the legs.

The practical importance of this one procedure, we think, is well emphasized by the following reports on the treatment of congenital pyloric stenosis. Williams reports in Australia that from the year 1928 to the year 1938, a 15 per cent mortality rate was found in operative cases of congenital pyloric stenosis. However, in the series from 1938 to 1941, the rate dropped to 2.8 per cent. Gius[2] reports a mortality of less than 2 per cent. In the last 64 patients operated upon there was only one death in the series. In line with this feeling, Dr. Ladd of Harvard Medical School has said that one thing he does not think is generally appreciated is that infants in the first 48 hours of life withstand major surgical procedures far better than they do a week or two hence.

Indeed, in regard to the fluid balance pre- and postoperatively on infants as well as on adults, the biggest advances in surgery in the last 20 years have been not in the actual technique of surgery but rather in the pre- and postoperative care of patients, especially with respect to fluid balance. With these things in mind I think we can realize that we are perfectly safe in operating upon infants.

All authorities agree pretty definitely that open-drop ether is the anesthetic of choice and they all regard it as one with an extremely low mortality if it is given by a person who has had some experience in giving anesthesia to children. Many times it is better to start anes-

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thesia with vinethene, a rapid-acting inhalation anesthetic with a wide range of safety, switching over to ether after anesthesia has been induced. Postoperatively respiratory infections and atelectasis occur very rarely in children. With the use of antibiotics at present we can feel more safe than we ever did before. Postoperatively children never have to be catheterized nor do they need enemas. They are usually quite ready and eager to take their nourishment and early ambulation is certainly never a problem.

The operations with which we are most concerned at the present are repair of harelip, circumcision, inguinal and unbilical herniorrhaphies, tonsillectomies and adenoidectomies. Within the first half year of life repair of harelip is carried out. This is a procedure that often involves more than one operation. And yet, there is no question in anyone's mind but that this should be done during the very, very early part of the child's life. This certainly cannot be called an emergency procedure. True, the deformity does interfere greatly with nutrition and undoubtedly puts a great mental strain on the parents, and for these reasons alone should be done early.

Circumcision is one procedure that is routinely practiced by us all within the first week postpartum if desired by the parents. The patients may be given Vitamin K preoperatively but certainly no one is greatly concerned or upset at the thought of doing this type of surgery in a child so young, although Dr. Lauterberg in Germany actually believes circumcision is best postponed until the child is a year or so old.

INGUINAL HERNIA

With inguinal hernia, a different problem is seen. We all know and it is generally agreed by Drs. Ladd and Gross, Larson, Bradford, Donavan, Bancroft and Humphreys, and others that inguinal hernias are actually, in an infant, due to patent processes vaginalis which has not closed as is the normal case. Within the first six months of life and even occasionally within the first year, spontaneous cures may occur when the neck of the sac becomes adherent and obliterates the process. After the first six months or year any spontaneous cures should be looked upon with askance. Generally, if these cases are followed long enough the scar at the internal ring will break down and the inguinal hernia will return, this occurring during puberty and early adult life. With an inguinal hernia there are three things you can do. One is nothing; two, surgery; three, truss. We are sure that most surgeons do not feel that a policy of doing nothing is justified. Dr. Rosenblatt in *Northwest Medicine* expressed the opinion that seems to be the general concensus. That is, that children under one year of age should not be subjected to surgery for hernia except where there is a complicating factor such as marked pain, a very large defect, incarceration, inability of retention, digestive disturbances, or other evidence that would indicate harm from the pathological process present. In the event that any of these appear, immediate surgery is indicated. And were it not for the fact that spontaneous cures do occur within the first six months, surgery would be advocated, as with Dr. Larson at Vanderbilt, when the pathological process is discovered. Dr. Ladd of Boston believes that a surgeon who only performs surgery on infants upon rare occasions or who has had no specialty training in this field should, in many instances, wait until the child is a year old or until the surgery is a little more easily performed.

The conservative treatment is that of a truss. Here again there is pretty general agreement in the field of pediatric surgery that a yarn truss is the only one that is adequate. This, too, has its faults in that as Dr. Ladd has reported, these trusses are rarely curative. They are a temporary measure and are sometimes ineffective due to the size of the hernia or the inaptitude of the parents. Another thing is that by their very nature, they are quite likely to become dirty and must be washed or thrown away and a new or clean one applied. In addition to this, many parents are extremely alarmed over the possibility of incarceration of the hernia and of the apparent genital defect they believe present. This adds to them and to the child a greater mental handicap than many of us realize. Dr. Ladd has been quoted as saying that if a truss is ineffective in maintaining reduction of the hernia, operation should be resorted to regardless of age. He feels that some surgeons still advocate putting off surgery until seven or eight years of age for fear of contamination from the urine. This, Dr. Ladd feels, is a rather foolish thing.

At Vanderbilt the feeling is that if the operation is designed for the patient and kept as simple as compatible with good surgery, herniorrhaphy may be performed at the time the diagnosis is made. Dr. Larson reports 119 operations performed on 111 patients and presents some rather interesting facts that I should like to repeat.

There were 24 incarcerated hernias in the 119 present, 20 of these being present when first seen in the hospital. Of the 24 incarcerated hernias, 21 or 87 per cent occurred under the age of 37 months and 8 or one-third under 13 months, 6 actually occurring while the patient was wearing a truss. Repeated incarceration had occurred in 14 of these patients prior to being seen. Several of the children had actually

had incarcerated hernias reduced under anesthesia prior to the time they were seen and yet no surgery had been advocated for correction of the hernia. In the 36 patients who were seen wearing trusses, 18 of them had actually progressed increasingly in size in spite of the truss and in only 4 was the truss actually maintaining reduction of the hernia.

Of the 119 herniorrhaphies performed, 10 per cent were on patients younger than 6 months, 18 per cent younger than one year, and 50 per cent under the age of 37 months. No recurrences have been noted to present. There was one death.

Another report by Dr. Johnston in *The Ohio State Medical Journal*, presents a group of nine patients, five of whom were between the ages of 11 weeks to 1 year. All of these were operated upon for acute strangulation of an inguinal hernia.

Other surgeons believe as does Dr. Bancroft that an incarcerated hernia should be reduced, but that surgery should be deferred. The incidence of gangrene is extremely small and he feels that it is small enough to accept the risk of reducing the incarceration, even under anesthesia, and then at a period of three to seven days following this, the hernia is repaired. This allows the edema at the site of the incarceration to subside. The hernia should not, however, be left unrepaired.

Another consideration in the matter of inguinal hernia is the reported cases of torsion of an undescended testicle in the presence of hernia with resulting gangrene and infarction of the testicle or ovary in the hernial sac, this necessitating surgical removal. Surgical repair on an inguinal hernia is certainly simple using a modified Ferguson repair. No postoperative complications of residual hydrocele, testicular atrophy, or recurrence has been found reported.

UMBILICAL HERNIA

Umbilical hernia, in some respects, is like inguinal hernia. Incarceration is reportedly less common and yet it is a real danger. We think the indications for operation are much the same as those given for inguinal hernia and we believe that the procedures recommended by Drs. Ladd and Gross are certainly to be followed for the first six months. They believe that the method of treatment under the age of six months is to strap an umbilical hernia with adhesive tape. After this time, however, it has a definitely diminishing value and has practically no merit for a baby more than a year old. After the twelfth month of life a hernial opening which is less than 1 cm. in size should cause little concern as it will become obliterated as the child grows. However, those from 1.5 cms. to 4 cms. or more in diameter should always be repaired.

In the past year we have had two cases of umbilical hernia, one of them being incarcerated and one of them not.

Case 1. G. K., six-year-old colored girl seen on morning of August 15, 1948, with severe intermittent abdominal cramps of six hours' duration with nausea and vomiting. Physical examination revealed a mass 2 x 2 cms. within a protruding umbilicus. Diagnosis of umbilical hernia was made and immediate surgery performed. A Richter's type hernia was found and repaired in the usual Mayo technique. Postoperative course was uneventful and result excellent to date.

Case 2. J. W., two-year-old white girl. History of asymptomatic umbilical hernia with hernial ring measuring 2 cms. in diameter. Repair was a Mayo type repair. Postoperative course was uneventful and result to date is excellent.

TONSILLECTOMY AND ADENOIDECTOMY

The next procedure we wish to consider in this paper is tonsillectomy and adenoidectomy in infants. In reading through the literature we have found very few references to this subject. We believe, however, there are many times definite indications for tonsillectomies and adenoidectomies being done in children under a year of age and those in the next two to three years. We do not believe in waiting until the child is five or six because we feel this comes under the same heading as putting off surgery in hernias. As in hernias there are definite indications for doing tonsillectomies and adenoidectomies on infants. We have had many children with recurrent tonsillitis, recurrent otitis media, recurrent infection of the adenoids with postnasal drip and continued cough. These children do not eat well, they do not feel well and they are always sick. They get over one episode and within a week or two are back in another. We have had in the past year three cases between the ages of seven and eleven months of age at the time tonsillectomy was performed. We know that the adenoid tissue will often grow back and require subsequent removal but we do not feel it is fair to risk deafness during adult life because we are afraid to take out tonsils and adenoids in a child who is having recurrent otitis media at the age of ten months, one year, or older. We have, also, during the past year seen one child who has developed a recurrent pyelitis as a result of recurrent tonsillitis. We have seen another child who has had one kidney removed due to a perinephritic abscess which developed following an acute tonsillitis. The risk of tonsillectomy and adenoidectomy is negligible but the risk of procrastination is certainly dramatically illustrated here.

During the acute infection antibiotics and sulfas will cause the infection to subside. After they are cleared up and given a week or two to get on their feet and let some of the edema in

the infected tissues subside, infants can be subjected to tonsillectomy under ether anesthesia with no greater risk than in a child five or six years of age. The following illustrative case reports will further demonstrate our belief in this.

Case 1. J. W., nine months at time of tonsillectomy and adenoidectomy. Acute tonsillitis at age of six months, recurred in one week and one month. Tonsillectomy and adenoidectomy February 4, 1949, child has been perfectly well since that time.

Case 2. D. D., eleven months at time of tonsillectomy and adenoidectomy. First seen at seven months with tonsillitis and otitis media. Again seen at eight and nine months of age with same symptoms. Tonsillectomy and adenoidectomy performed February 4, 1949. Child perfectly well since.

Case 3. J. M., eleven months at time of tonsillectomy and adenoidectomy. First seen at six months with temperature and cough. Cough persisted and was more severe when lying down or nursing. Postnasal drip present but lessened with $AgNO_3$ painting of adenoid tissue. Seen every two or three weeks since that time with upper respiratory infection and otitis media. Tonsillectomy and adenoidectomy performed March 4, 1949. No recurrence of upper respiratory infection or otitis media since that time.

Case 4. M. L., nineteen months at time of tonsillectomy and adenoidectomy. Recurrent attacks of tonsillitis and otitis media since age of one year. Temperature would run to 104° convulsions would follow. Tonsillectomy and adenoidectomy performed February, 1949. Since tonsillectomy and adenoidectomy child has been perfectly well.

Case 5. J. S., twenty months at time of tonsillectomy and adenoidectomy. First seen at eight months of age with tonsillitis. Temperature would rise to 104° to 105° with each episode and convulsions would follow. Seen at monthly intervals until time of tonsillectomy and adenoidectomy which was performed November 3, 1948. Child has had one sore throat since that time.

Case 6. E. V., twenty months at time of tonsillectomy and adenoidectomy. First seen at age of seven months with bilateral otitis media and tonsillitis. Treated at monthly intervals with penicillin and sulfa until tonsillectomy and adenoidectomy on February 4, 1949. Since that time child has been seen once with otitis media.

Case 7. J. W., twenty-one months at time of tonsillectomy and adenoidectomy. First seen at age of eight months with acute tonsillitis and bilateral otitis media. Recurrence of this at regular intervals during next year. No further trouble since tonsillectomy and adenoidectomy performed February, 1949.

Case 8. B. L., twenty-two months at time of tonsillectomy and adenoidectomy. Tonsillitis and otitis media every two months since one year of age. Since tonsillectomy and adenoidectomy in February, 1949, there has been no recurrence.

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Experience and Judgment

What have any of us learned from experience? If we are honest with ourselves we must answer, "Not as much as we should have." Without a lifelong and unflinching honesty with ourselves we can learn nothing. We may dress the shop window as we like, we may develop a sales personality that is convincing to others, but unless our accounts and our stock-taking are entirely honest we shall finish as cheapjacks. The greatest of the men before us said, "The art of Medicine is long and time is fleeting. Experience is fallacious and judgment difficult." But with experience, carefully recorded and sorted, judgment will come.

Experience properly used gives us a set of standards by which fresh experiences can be judged. We learn to sum up our patients quickly and fairly accurately as human beings—if they are genuine, self-dramatizers, or humbugs, if they are brave or timid, if they are minimizers or exaggerators, if they are concealing something or merely nervous—and in the light of this assessment we are able to allot a correcting ratio to the symptoms they relate that gives it an absolute value in our diagnostic assessment. We learn to evaluate pain, particularly its severity and its nature, and to construct a scale of our own by which we associate certain pains with certain diseases. We learn that too much pain in too many places is just as much indication that nothing is seriously wrong as no pain. We learn to know when a patient is ill, when one who has been ill is getting better, or when one who was on the road to recovery has taken a turn for the worse. We come to say by instinct rather than reason, "That child is too ill to be suffering from appendicitis." "That pain is not severe enough for gall-stone colic." We learn what disease to expect at certain ages, in either sex, and in persons of certain appearance, occupations, or bodily habitus. We become so familiar with all the characters of common complaints that one single unfamiliar feature strikes a warning note without our having had recourse to the intellectual process of reasoning.—Sir Heneage Ogilvie, K.B.E., British Medical Journal, No. 4629, September 24, 1949.

Transient Diabetes Insipidus Complicating Bacterial Endocarditis

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THIS paper deals with the clinical observations on a patient with acute bacterial endocarditis due to hemolytic staphylococcus aureus, whose illness was complicated by transient diabetes insipidus, an event hitherto not recorded in the literature as occurring during the course of bacterial endocarditis. The organism recovered from the blood demonstrated a low sensitivity to penicillin, but in spite of this, massive doses of penicillin over a prolonged period resulted in a cure. .

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REPORT OF CASE

P. L., C. C. H. number 286378, a seventeen-year old white schoolgirl, was admitted to the Contagious Division of Cleveland City Hospital on the evening of April 30, 1947, with chills, fever, stiffness of the neck, and delirium. Except for an attack of rheumatic fever at age nine and again a year later, her health had been good until six days prior to admission when she developed malaise, a low grade fever, a slight nonproductive cough, and anorexia. These symptoms continued until April 27, when the temperature rose to 40 degrees C. accompanied by a shaking chill, followed by the appearance of a red, painful purpuric spot on the right ankle. On April 28 she became drowsy and was admitted to a local hospital where she remained until April 30. At that time she developed stiffness of the neck and was transferred to the Contagious Division, Cleveland City Hospital, with the provisional diagnosis of meningitis.

PHYSICAL EXAMINATION

The patient was a well-developed and well-nourished girl who was disoriented, and appeared seriously ill. The temperature was 38.2 degrees C., the pulse rate 110, and the blood pressure 120/72. There were multiple petechiae and purpuric areas over the hands, feet and chest. Subungual splinter hemorrhages were present in most of the fingers. The conjunctivae were clear and there were no hemorrhages of the ocular fundi, but the left optic disc showed questionable blurring. The tympanic membranes were intact. There was no discharge from the nares. Petechiae were noticed in the soft palate and in the buccal mucous membrane. The neck was moderately rigid. The left border of cardiac dullness was percussed in the left anterior axillary line, and there was increased activity over the left ventricle. The first heart sound at the apex was followed by a loud, moderately harsh systolic murmur, heard best at the apex, and transmitted to the left axilla and along the left sternal border to the second left parasternal area. The aortic second sound was clear and the cardiac mechanism was normal. The peripheral arteries were soft and compressible, and all peripheral pulses palpable and equal bilaterally.

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The abdomen was not remarkable except for a questionably palpable spleen and tenderness in the left upper quadrant. No abnormalities of the back were noted. The joints of the right arm and leg were painful on movement but were not swollen or reddened. The deep tendon reflexes were all hyperactive, Kernig's and Brudzinski's signs were present, but the Babinski sign was absent.

LABORATORY DATA

The urine was cloudy, acid, with a specific gravity of 1016. There were no albumin, sugar or acetone. No formed elements were noted other than an occasional white blood cell. The hemogram revealed the hemoglobin to be 16 grams, the red blood count 4,540,000, white blood count 18,900, with a differential count of 74 polymorphonuclear leukocytes and 26 lymphocytes. Lumbar puncture revealed ground glass fluid with a cell count of 340 cells, 142 of which were red blood cells, 164 polymorphonuclear leukocytes and 34 mononuclear cells. The Pandy test was 3 plus, the Ross-Jones 3 plus, the spinal fluid protein was 90 mgm. per cent, and the chlorides 411 mgm. per cent (678 mgm. per cent as NaCl). No organisms were seen on direct smear. The blood cultures on April 30 and June 1 showed identical hemolytic staphylococcus aureus. Eighteen subsequent blood cultures during her hospital stay were all negative. No organisms were grown from the spinal fluid.

The skin over several of the petechial and purpuric areas was denuded and Gram stains were made of the expressed serum. These showed clusters of gram positive cocci, several of which were phagocyted.

Sensitivity tests demonstrated the causative organism to be inhibited by a concentration of four units of penicillin (large inoculum), one unit of penicillin (small inoculum), and 50 micrograms of streptomycin, according to Rammelkamp's tubular dilution method.

The admission electrocardiogram showed a prolongation of the auriculo-ventricular conduc-

tion time and a slight right axis deviation. Later records reverted to normal.

HOSPITAL COURSE

After the diagnosis was established the patient was transferred to the medical service on June 1st. She was given two grams of sulfathiozole, 2 grams of sulfadiazine, and continued on a dosage of 0.5 grams of each every four hours. This was continued to a total of 23 grams of each, and stopped on June 9, 1947. Penicillin was likewise begun, 100,000 units intramuscularly every hour, and 1,000,000 units were given intravenously on June 2 and June 3. On June 4 intravenous penicillin was increased to 2,000,000 units daily and continued until June 10. The intramuscular injections of penicillin were increased to 200,000 units every hour on June 7, and to 400,000 units every hour on June 8. On June 9 this was reduced to 200,000 units every hour and maintained at that dosage through the remainder of her active therapy. The total penicillin dosage was 451,000,000 units given over a period of 108 days; during the last 97 days of therapy she received 4,800,000 units daily.

From June 11 to June 25 she received Retentin* (4′ carboxyphenylmethanesulfonilide) 1 gram every 2 hours, to a total dosage of 178 grams. At no time did she develop signs of toxicity on this dosage. In addition 3,500 cc. of whole blood were given by multiple transfusions through her hospital stay.

Repeated penicillin blood levels throughout her full course of therapy ranged between three and eight units. Most of the time steady levels of eight units were obtained. There was no evidence that Retentin, in the dosage employed, significantly elevated the blood penicillin levels.

Her hospital course during the first twenty-three days was extremely stormy. The temperature remained elevated, with daily variations of 1.5 degrees C. until it reached a peak of 41 degrees C. on the tenth hospital day. Acetylsalicylic acid, 1.6 grams, was given, with a transient drop to 37 degrees C., and was repeated on her eleventh hospital day. Thereafter the temperature began to decline until the twentieth hospital day when for the first time it reached 37 degrees C. The following day she had a chill, and developed right upper quadrant pain with severe costovertebral angle tenderness and muscle spasm. The temperature rose to 40.5 degrees C. This was interpreted as a septic embolus to the right kidney or in the perinephric region, since repeated urine examinations failed to show the presence of red blood cells. This was the last embolic phenomenon noted, and thereafter the temperature began gradually to drop until it stabilized at 37 degrees C. or below by the 71st hospital day, with the exception of one elevation to 37.8 degrees C. on the 76th hospital day, which was attributed to an intercurrent common cold. Penicillin therapy was continued unchanged during an afebrile period of thirty-nine days, and she was observed for another twenty-seven days during which time she gradually resumed activity.

After the first twenty-four hours in the hospital the patient was fully conscious. She never received more than 3,000 cc. of parenteral fluids daily, this being given mainly as a vehicle for intravenous penicillin. Her oral intake increased gradually from 800 cc. daily on the second hospital day, to 5,200 cc. on the eighth hospital day. On the fourth hospital day bilateral papilledema of 1 diopter was noted, although the neck stiffness had subsided; on the ninth day she developed unbearable thirst and the oral fluid intake rose to 27,400 cc. or 6.8 gallons; on the tenth day the oral intake was 20,400 cc. or 5.1 gallons; on the eleventh day 10,050 cc., on the twelfth day 8,075 cc., and on the thirteenth day 4,800 cc. The urinary output followed the intake of fluids closely, and during the height of the polyuria the specific gravity of the urine fell to 1.002 (See Table 1). The oral fluid intake gradually dropped to 3,400 cc. by the nineteenth hospital day, and never exceeded 3,000 cc. thereafter, for the most part averaging 1,500 cc. to 2,200 cc. daily. By the tenth hospital day, coincident with the subsidence of polyuria and polydypsia, the bilateral papilledema had almost disappeared. Spinal punctures were not repeated following the admission tap since it was felt that she was too ill, and little was to be gained from the procedure.

TABLE 1

RECORD OF FLUID INTAKE, OUTPUT, URINARY SPECIFIC GRAVITY, AND MAXIMAL TEMPERATURE ELEVATION IN DEGREES CENTIGRADE DURING FIRST THREE WEEKS OF HOSPITALIZATION.

There is no relation between the temperature elevation and the oral intake; during this time of maximal polyuria and polydipsia the patient exhibited the typical very dry skin, with a striking absence of hydrosis. Figures in parentheses indicate parenteral fluids, employed as a vehicle for penicillin.

Date	Intake in cc.	Output in cc.	Sp. Gravity	Max. Temp.
4/30/47	No record	No record	1016	40.0
5/1/47	800 (1500)	No record	1016	40.0
5/2/47	1700 (3700)	3200	———	39.5
5/3/47	1500 (3000)	6000	1016	40.2
5/4/47	3200 (3000)	6000	———	39.8
5/5/47	3800 (3000)	6400	1013	39.5
5/6/47	4000 (3000)	8540	———	40.2
5/7/47	5200 (2500)	8400	1006	40.0
5/8/47	27400 (1500)	20500	———	40.2
5/9/47	20400 (1500)	17000	1002	41.0
5/10/47	10050 (1500)	10100	———	40.6
5/11/47	8075 (750)	7000	———	39.5
5/12/47	4800	5050	1010	40.0
5/13/47	4200	3200	1015	38.8
5/14/47	5400	3400	1015	39.0
5/15/47	5600	4000	———	39.3
5/16/47	4200	3400	1012	39.2
5/17/47	3600	3875	1010	39.0
5/18/47	3440	2000	———	39.0
5/19/47	2400	1000	———	38.8
5/20/47	2000	1450	1020	40.5

Another interesting feature was the change in the character of the apical systolic murmur which gradually became harsher and more widely transmitted, so that by the time the patient was discharged, the murmur completely obliterated the first heart sound and was heard over the entire precordium.

The first X-ray examination of the chest was done on June 15 when the transverse diameter of the heart was found to be 10 per cent greater than the expected normal for her height and weight, according to Ungerleider's scale.

The patient has been seen repeatedly since discharge and has been found to be in excellent health. At present, ten months following her release from the hospital, she has maintained

* Supplied through the courtesy of Sharpe and Dohme.

her normal weight and has attended school, able to participate in all routine activities without limitations. Her heart, both clinically and fluoroscopically, has shown no change.

DISCUSSION

Diabetes insipidus is a rather rare clinical condition. Rowntree[7] gives the incidence as 16 in every 100,000 hospital admissions. Fink[2] in reporting a series of 107 autopsied cases collected from the literature, found diabetes insipidus to occur in 0.01 per cent of all treated hospital patients. Usually the condition results from neoplasms involving the supraoptico-hypophysial system primarily, by direct extension, or by metastases; syphilis, tuberculosis, actinomycotic abscess, epidemic encephalitis, certain rare disorders of metabolism, and traumatic lesions account for the majority of the remaining cases. A certain number have no known etiology. Nephrogenic diabetes insipidus has been reported.[10] Only nine instances (8.4 per cent) in Fink's series[2] were due to other inflammatory lesions, and of these one resulted from a metastatic abscess originating in a ruptured appendix.[6] Jones[5] in a series of 42 clinical cases, reports one instance in which diabetes insipidus may have followed a septic abortion.

Involvement of the water balance system is likewise rare as a result of direct extension of a nearby inflammatory process. Although single case reports occur sporadically in the literature,[8, 11] Yashin did not find a single case of diabetes insipidus in an analysis of 326 cases of neurological complications accompanying infections both of the temporal bone and paranasal sinuses.[12]

Transient polyuria of levels consistent with diabetes insipidus is by no means unknown. It has been recounted in such varied conditions as hysteria,[7] pregnancy,[1] treated syphilis, trauma, and during convalescence from a number of acute infections, notably typhoid fever.[4]

A survey of past writings reveals no instance of diabetes insipidus, either transient or permanent, resulting from acute or subacute bacterial endocarditis. As these affections often cause embolic occlusions of the cerebral vessels, it is indeed noteworthy that diabetes insipidus is not more frequently observed.

That the supraoptico-hypophysial system is responsible for the control of water balance in the experimental animal was demonstrated by Fisher, et al.,[3] who found that more than fifty per cent of the system must be ablated bilaterally to produce permanent diabetes insipidus in the cat. Although we have no proof that a lesion in the supraoptico-hypophysial system caused the disturbance in water balance observed in our patient, yet favoring this possibility is (1) the simultaneous appearance of bilateral papilledema which subsided pari passu with the polyuria and polydipsia, and (2) the clinical evidence of meningeal irritation associated with inflammatory cells in the spinal fluid.

It is of interest to note that massive doses of penicillin arrested an infection caused by an organism notoriously resistant to therapy. Wilhelm, et al.,[9] have summarized the results in forty published cases of acute bacterial endocarditis treated with penicillin, of which 27 were due to staphylococcus aureus, and of these only six survived, a mortality of 78 per cent.

SUMMARY

1. A case of transient diabetes insipidus complicating the course of acute bacterial endocarditis of the mitral valve due to hemolytic staphylococcus aureus is presented.

2. The organism recovered from the blood stream possessed a low sensitivity to penicillin, but in spite of this, massive doses of penicillin given hourly by intramuscular injection over a period of 108 days resulted in a cure.

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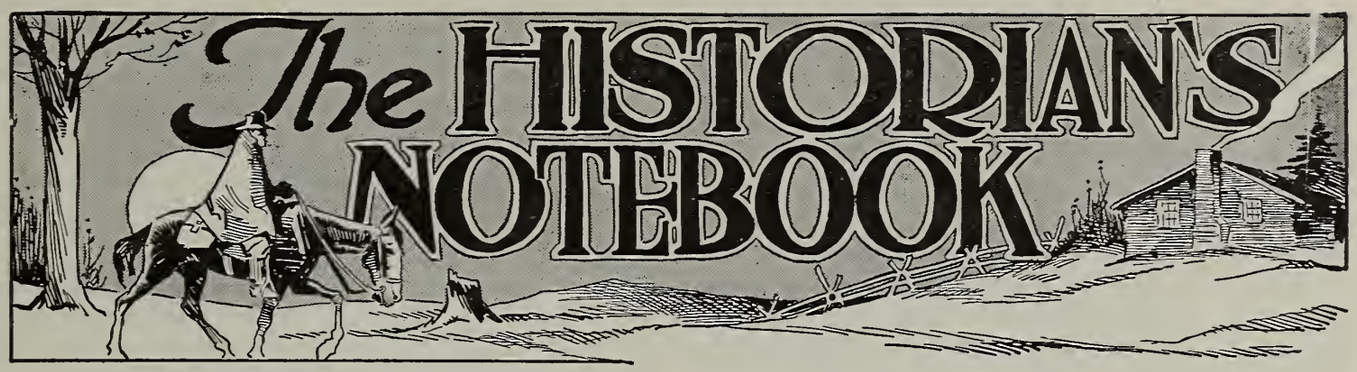
The Story Behind the Word

Asthma—This word dates back to antiquity and was employed by the ancient Greek physicians. Hippocrates referred to asthma nine times but left no clear cut clinical account. It is derived from the Greek word "Astma" meaning to pant, but is also given as coming from the Greek word "aenai" meaning to breathe hard.

Diabetes—We owe the name of this disease to Aretaeus of Cappadocia who lived in the Second Century A.D. He named the disease from the Greek word for siphon because "the fluid does not remain in the body but leaves it as by a siphon." The word diabetes or siphon comes from the Greek words "dia" or through and "baino" I go.

Batty—To go "batty"—literally to be possessed of the devil in the form of a bat.

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History of Medicine in Gallia County, Ohio

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A LITTLE French Colony of 500 over one hundred and sixty years ago was but the foam blown from the on-rolling waves of an advancing civilization sired by the fierce tornado of the French Revolution. The Bastille had fallen and great unrest was felt by the government and people who were just ready to grasp at anything to relieve their unhappy condition. It was at this most propitious of times for advancing schemes designed to swindle distressed, discouraged and peace-loving people that an American land syndicate opened in Paris; and through them the French Colony was informed that they owned a vast tract in America that would afford an ideal refuge for them. Upon their arrival at Alexandria, they found that their deeds did not give a perfect title to the land.

The Scioto Company which was responsible for their being cheated, patched up their affairs at Alexandria, Virginia, and arranged to have a public square cleared and a log block-house and cabins erected at Gallipolis.

Gallipolis is the highest town bordering on the Ohio river and the third city founded in Ohio, Marietta being first; Cincinnati second. Its name is a combination of Latin and Greek. Galli, genitive singular of Gallus, and polis, nominative of the Greek polis meaning city. Hence the name means City of the Gauls. The French were proud of their descent from the ancient race of Gauls.

SOUGHT EASY LIFE

The migration of the French Colony cannot be attributed to the lofty motives and heroic determination which animated the rugged New England pioneers who found firm foot-hold on bleak Plymouth Rock and offered prayers for their safety. Rather the French came over to have peace of mind, easy life, carefree feasts and balls, for the next evening after their arrival, all of their finery was unpacked to wear to a dance wherein much pleasure was indulged. This same spirit and love for a social life prevailed for many years. In fact a little of it still prevails.

Among these French settlers of 1790 was the first doctor to locate in Gallipolis. Dr. Antoine Francis Saugrain, physician, chemist and natural philosopher, was an active and plucky little Frenchman four and a half feet tall, full of vivacity, vitality and loved by his fellowmen. He took great pleasure in showing the curious operations of his blow-pipe and crucible; tricks with his phosphorous matches; his barometer and thermometer with the scales painted with a pen.

Dr. Andrew LaCroix, born in Normandy in 1766, was an obstetrician by profession and a Latin scholar by avocation. He came with or soon after the arrival of the early settlers and was there during the cholera epidemic in 1796. His profession requiring only his occasional attention, and his income from assisting at births being slender, he was forced to adopt other means of livelihood. It is said "he had a horse mill and distilled peach brandy." An employment not quite so poetical.

Gallia County was formed from a vast territory known as Washington County, April 30, 1803, shortly after Ohio was admitted as a state just thirteen years after Gallipolis was settled, June 8, 1790. Gallipolis is the county seat. "Gallia," the ancient name of France was given it in honor of the French settlers. It is situated in the southeastern part of the hilly country of the state on the beautiful Ohio River.

Many years ago studying for the profession of medicine was an entirely different matter from what it is today. A young man "read" with a physician and accompanied him on "his rounds" for a year, then went to Medical College for a year, after which he was qualified to "hang out his shingle."

Dr. Edward Naret was born in France; graduated in Paris and came to the United States in

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1800. He located in Gallipolis and married Dr. Antoine Francis Saugrain's daughter. His home is now owned by Mr. Howard Neal.

Dr. Jonas Safford was the fourth doctor as far as is known. He was born at Hardwick, Massachusetts, 1763, studied with his step-father at Bennington, Vermont. In 1811, when he was forty-eight years old, being influenced by his brother, Col. Robert Safford, who cut down the first tree in Gallipolis, Dr. Safford removed to the valley of Ohio, and settled in Gallipolis. He was everywhere regarded as a very able physician and was active in organizing the first Medical Society in Ohio and continued a member until his death.

Owing to the burning of the court house in 1877, the records of the early physicians were destroyed and unless some of the families remember (and usually they do not), it is impossible to get accurate data. A few names have been taken from tombstones.

EARLY GALLIA COUNTY DOCTORS

1824—Dr. Jacob Kittredge died at age of 45, August 22, 1824.

Dr. James Hamlin died August 5, 1824.

1825—Dr. Elisha Morgan, Gallipolis, born 1791, died 1870.

1834—Dr. Perin Gardner, Gallipolis, graduated from Starling Medical College, Columbus; surgeon; anatomy professor at Starling.

1846—Dr. N. B. Sisson, Bidwell, University of Louisville.

1848—Dr. J. C. Rathburn, born September 27, 1826; graduated from Starling Medical College, Columbus, 1848; practiced in Gallia County until 1868 when he came to Gallipolis. His acquaintance knew him as a gentleman, honest, tender and sympathetic.

Dr. George W. Livesay graduated from University of Virginia and Columbia College; located at Gallipolis where, during the Civil War, he had charge of the hospital. In 1873, he moved to Ironton, Ohio, and engaged in the active pursuit of his profession until his death August 8, 1900, at the age of 76.

1850—Dr. John Sanns, born August 1, 1826, graduated from Starling Medical College, Columbus, 1850; practiced in Gallipolis. He was very brilliant and had a lucrative practice.

1854—Dr. W. W. Mills, Gallipolis, graduated from Starling Medical College, Columbus.

Dr. Clairbourn D. Wall, Gallipolis, Cincinnati Medical College; died 1882.

1857—Dr. James Johnston graduated from Starling Medical College, Columbus; practiced in Kyger 25 years and Gallipolis until his death. He was the doctor in charge during the smallpox epidemic.

Dr. Daniel Patterson, Cadmus, graduated from Starling Medical College, died 1916.

1864—Dr. David T. Jenkins graduated from Eclectic Medical College, Cincinnati.

Dr. Eli G. Alcorn graduated from Eclectic Medical College, Philadelphia; practiced in Hamlin, West Virginia, then came to Gallipolis.

Dr. Charles Russell Morgan, Gallipolis, graduated from Starling Medical College, died 1874.

Dr. Rufus D. Jacobs, Vinton and Rio Grande, graduated from Cleveland Medical College; beloved by his community; killed by train.

1868—Dr. William Chauncy Hall Needham was born in Connecticut, 1845, graduated from Johns Hopkins Medical 1868; located at Gallipolis 1868, married, 1870; entered Civil War when 17 years old; practiced during Yellow Fever Epidemic; elected Senator from this district; died 1885.

1869—Dr. Fred A. Cromley, Gallipolis, graduated from Cincinnati College of Medicine and Surgery; member of Board of Health; assisted Dr. Needham during the yellow fever epidemic in 1878.

1871—Dr Jehu Eakins, Patriot and Gallipolis, graduated from Jefferson Medical College, Philadelphia; fastidious, yet pleasant and efficient.

1872—Dr. Edward W. Parker, Vinton and Gallipolis, graduated from Cincinnati Medical College; died May, 1903.

1874—Dr. J. B. Dustin, Vinton, graduated from Medical College of Ohio, Cincinnati.

Dr. James T. Hanson, Gallipolis, graduated from Cincinnati Medical College; jovial, good fellow, known by his laugh.

1875—Dr. Thomas Northrup, Gallipolis, graduated from Cincinnati Medical College.

1877—Dr. Clayton Barton, Addison, graduated from Kentucky School of Medicine, Louisville; practiced over large area.

Dr. David A. Howell, Gallipolis, graduated from Ohio Medical College Cincinnati; died 1899.

1880—Dr. Henry P. Gerlack, Crown City, graduated from Medical College of Ohio, Cincinnati.

Dr. W. J. Fletcher, Chambersburg, graduated from Miami Medical College, Cincinnati.

1881—Dr. Edwin B. Morrison graduated from Starling Medical College, Columbus.

Dr. George K. Ewing, Ewington, graduated from College of Physicians and Surgeons, Baltimore, Maryland.

Dr. S. W. Williams graduated from Miami Medical College, Cincinnati; practiced in Mercerville, then in Gallipolis.

1882—Dr. C. A. Rife, Kyger, graduated from Starling Medical College, Columbus; surprised everyone by his dexterity; lost one hand when he was six years old.

Dr. W. W. Miller, Thurman and Vinton, graduated from Jefferson Medical College, Philadelphia.

1883—Dr. Morris Tipton graduated from Medical College of Ohio, Cincinnati. In 1913, he became Probate Judge in Gallipolis. In 1917, he went to Columbus on staff of Ohio State Insane Hospital; died 1930.

1884—Dr. David K. Shaffer, Peniel, graduated from Starling Medical College, Columbus.

1886—Dr. L. P. Fletcher, Pine Grove, graduated from Miami Medical College, Cincinnati.

Dr. George Vanden, Gallipolis, graduated from Medical College of Ohio, Cincinnati; eye specialist.

1887—Dr. H. Dale Strausbaugh graduated from Starling Medical College, Columbus.

1888—Dr. Charles C. Parker, Porter and Gallipolis, graduated from Medical College of Ohio, Cincinnati.

Dr. Orin S. Mills, Gallipolis, graduated from Medical College of Ohio, Cincinnati.

1889—Dr. J. S. Webster, Waterloo and Gallipolis, graduated from Miami Medical College, Cincinnati.

Dr. H. M. Hamilton, Vinton, graduated from Medical College of Ohio, Cincinnati.

1890—Dr. Chas. W. Ely, Cheshire, graduated from Starling Medical College, Columbus.

Dr. Edward O. McCall.

1892—Dr. Louis C. Bean, Gallipolis, graduated from Starling Medical College, Columbus.

Dr. Luther B. Turner, graduated from Starling Medical College, Columbus.

Dr. Alexis B. Parker graduated from Cincinnati College of Medicine and Surgery.

1893—Dr. John Wm. Bargar graduated from Medical College of Ohio, Cincinnati.

Dr. Dan J. Webster graduated from Miami Medical College, Cincinnati.

1894—Dr. John Winn, Rio Grande, graduated from Starling Medical College, Columbus.

Dr. John B. Alcorn, Gallipolis and Columbus, graduated from Kentucky School of Medicine, Louisville; member of Board of Health; postgraduate course at Vienna, New York; very successful; moved to Columbus in 1910; killed June 18, 1942.

Dr. Ella G. Lupton, Gallipolis, graduated from Woman's Medical College, Philadelphia.

Dr. E. E. Ellsworth, Gallipolis and Ironton, graduated from University of Louisville School of Medicine.

Dr. S. G. Martt, Crown City, graduated from University of Louisville School of Medicine.

Dr. Richard F. O'Connell, O. H. E., Cadmus, University Medical Dept., Washington D. C.

Dr. Gustave A. Mack, Gallipolis, Bellevue Hospital Medical College, New York.

1895—Dr. Claud B. Parker, Gallipolis, graduated from Medical College of Ohio, Cincinnati.

Dr. Robert Howell, Patriot and Gallipolis, graduated from Medical College of Ohio, Cincinnati.

1896—Dr. Daniel Patterson, Cadmus, graduated from Starling Medical College, Columbus.

Dr. Edwin E. Martindale, Crown City and Chesapeake, graduated from Medical College of Ohio, Cincinnati.

Dr. A. T. Clark, Vinton, graduated from Ohio Medical University, Columbus; died, 1916.

HAD LOGAN HOSPITAL

1897—Dr. J. S. Cherrington, Bidwell, graduated from Ohio Medical University, Columbus; later had a private hospital at Logan, Ohio.

Dr. T. J. Allison, Rio Grande, graduated from Baltimore Medical College.

Dr. Wm. E. Howell, Rio Grande and Gallipolis, graduated from Medical College of Ohio, Cincinnati; Gallia County's first health commissioner. He was found dead in his auto at the side of the road, after attending a confinement case all night, January 21, 1939.

Dr. W. H. Wilcox, Vinton and Columbus, graduated from Ohio Medical University, Columbus; said to have been in Mexican War.

1898—Dr. Elmer E. Clark, graduated from Barnes Medical College, St. Louis, Missouri.

20th CENTURY DOCTORS

1900—Dr. George A. Barton, Gallipolis, graduated from Cincinnati College of Medicine and Surgery.

Dr. Bertie V. Swisher, Addison, graduated from Cincinnati College of Medicine and Surgery.

Dr. William Pritchard graduated from Miami Medical College, Cincinnati. He became a member of the O. H. E. Medical Staff in 1903. Two years later he was made superintendent serving until 1911 when he resigned to take up practice of his profession in Gallipolis. In July, 1916, Governor White appointed him superintendent of Columbus State Hospital. He served in the Medical Corps during World War I at Camp Sherman. He died Nov. 11, 1936.

1903—Dr. Kromer C. Ice, Rio Grande and Vinton, graduated from College of Physicians and Surgery, St. Louis, Missouri.

1906—Dr. Homer V. Lusher, Crown City, graduated from Miami Medical College, Cincinnati.

Dr. J. W. Barger graduated from Ohio Medical University, Columbus.

1907—Dr. Charles E. Holzer, Sr., Gallipolis, graduated from Starling Medical College, Columbus.

1909—Dr. John S. Biddle, Gallipolis, graduated from Baltimore Medical College.

Dr. H. L. Crary, Vinton, graduated from Starling Medical College, Columbus.

1910—Dr. Everett F. Clouse, Vinton, graduated from Starling Medical College, Columbus.

Dr. J. C. Strausbaugh, Vinton, graduated from Starling Medical College, Columbus.

1912—Dr. S. C. Caldwell, Vinton, graduated from Starling Medical College, Columbus.

Dr. Fletcher Langdon graduated from Miami Medical College, Cincinnati.

1915—Dr. Leo C. Bean, Gallipolis, graduated from Johns Hopkins University School of Medicine, Baltimore, Maryland; one of the originators of the Gallipolis Clinic.

1928—Dr. Francis W. Shane, Gallipolis, graduated from Ohio State University College of Medicine; Gallia County health physician, 1932.

Dr. Geo. D. C. Thompson, graduated from Ohio State University College of Medicine; Gallipolis Clinic.

1930—Dr. W. Lewis Brown, Gallipolis, graduated from Jefferson Medical College, Philadelphia.

Dr. N. A. Martin, Gallipolis, graduated from Washington University School of Medicine, St. Louis, Missouri; one of the originators of Gallipolis Clinic.

1933—Dr. Homer B. Thomas, Gallipolis, graduated from the State University of Iowa College of Medicine; one of the originators of Gallipolis Clinic.

1938—Dr. N. Howard Foster, Gallipolis, graduated from University of Cincinnati College of Medicine; school physician.
Dr. George Mitchell, Centerville, graduated from Ohio State University College of Medicine.
1943—Dr. Floyd M. Beman graduated from Ohio State University College of Medicine.
Dr. John G. Gibert, Gallipolis, graduated from University of Cincinnati College of Medicine; was on the staff of Holzer Hospital, now a general practitioner.
Dr. John H. Hege, Gallipolis Clinic, graduated from Hahnemann Medical College and Hospital of Philadelphia.

A CALL TO A CAUSE

"A call to a cause" constitutes life and is great in its implications. Born in the conditions surrounding us, it demands attention immediately. The call represents a job to be done. It takes men to do it. We have heard some of these calls. "Remember the Lusitania." "Remember the Maine." "Remember Pearl Harbor." These were direct calls to which men and women answered. The following men of our noble profession went forth to meet the call in their own time.

MILITARY SERVICE

Dr. W. S. Newton graduated from Medical College of Ohio, Cincinnati; city councilman; postmaster eight years; member of pension board; surgeon in 91st and 193rd Ohio regiment in Civil War. Pallbearers at his funeral were his colleagues: Dr. J. C. Rathburn, Dr. John Sanns, Dr. E. G. Alcorn, Dr. W. W. Mills, Dr. D. A. Howell and Dr. James Johnston.

Dr. N. B. Sisson: graduated from University of Louisville School of Medicine, 1846; served with 97th company of Ohio in Civil War; located at Bidwell.

Dr. James Johnston: enlisted when Civil War broke out and became the assistant surgeon of the 116th O.V.I., and was commissioned in 1862. He resigned on account of ill health, but was again commissioned and assigned to the 141st O. V. I. and served to the end of hostilities.

Dr. W. W. Mills: enlisted in the 81st Ohio in 1861, was surgeon for three years; was U. S. Pension Examiner. During the epidemic of yellow fever in 1878 he attended many cases.

Dr. Perin Gardner: graduated from Starling Medical College, Columbus; surgeon in Civil War for three years; instructor of anatomy at Starling Medical College, Columbus; physician and surgeon at Marine Hospital, Gallipolis.

Dr. John B. Alcorn: in 1898, entered the Spanish American War; was commissioned, sent to (Chicamauga) Park, Tennessee, then to Knoxville, Tennessee, with the Sixth Ohio Reg. of Toledo, Ohio, then to Cuba. He belonged to National Guards.

Dr. J. B. Garrett: at one time ambassador to Mexico. He was in Civil War in 1862. He died in 1938 at the age of 93.

Dr. C. E. Holzer: enlisted in the medical corps in World War I.

Dr. S. L. Bossard: graduated from Loyola University School of Medicine, Chicago, 1916. In 1920 he became a staff member of the Ohio Hospital for Epileptics which he still holds. He served in World War I, six months as First Lieutenant, Medical Corps; World War II, six months Lieutenant Colonel, M. C.: L. M. C. L.: M. C. R. A.

Dr. N. A. Martin: one of the originators of our "Gallipolis Clinic" as specialist in Eye, Ear, Nose and Throat, entered the armed service November 6, 1940, as Captain in the Medical Corps Reserve. First called to active duty with the 37th division as Battalion Surgeon of 166th Infantry Regiment. In 1942 he was transferred to Letterman General Hospital, San Francisco, for overseas training; April, 1942: assigned to 155th Station Hospital Unit being activated for overseas duty. In May, 1942, sailed for the South Pacific combat area; September, 1942, organized and was commanding officer of the 14th Portable Hospital 32nd Division for combat duty in New Guinea and Australia. After returning to the States in October, 1943, he became chief of Eye, Ear, Nose and Throat Section and Rehabilitation of the Hard of Hearing at Hoff General Hospital, Santa Barbara, California. This was one of the three Army hearing centers that were organized during the war. He was released April, 1946, as Lieutenant Colonel.

FATHER AND SONS

Dr. Eli G. Alcorn: University Medical College of Kentucky; graduated from the medical department Eclectic Medical College of Pennsylvania. Specialized in eye, ear, nose and throat. He was interested in all civic activities and moved to Columbus in 1921. He died at the age of 95 in 1939 at Columbus.

Dr. John B. Alcorn: University of Louisville School of Medicine, 1894; Gallipolis. He maintained offices with his father, Eli G. Alcorn. In 1900, he built a home with offices therein; became a very efficient physician; was very active in lodges. He was Eminent Commander of Knight Templers; Exalted Ruler of Elks; president of Board of Education. In 1902 he bought the first gas automobile in Gallipolis; moved to Columbus in 1910 becoming a very popular and prosperous physician.

Dr. James Garfield Alcorn: University of Cincinnati College of Medicine, 1902; Gallipolis one year; moved to Columbus in 1904 where he still operates the "Alcorn Eye Hospital."

ONLY WOMAN DOCTOR

Dr. Ella G. Lupton: graduated from the Woman's Medical College, Philadelphia, Pennsyl-

vania, in 1894. In 1896-97 she was on the staff of Toledo State Hospital. She located in Gallipolis in 1894, being the only general practicing "woman physician" in the county. No opposition to a woman physician was ever manifested by the men physicians of the county. This was shown by making her a life member of the Gallia County Medical Society at its meeting, December 29, 1947. In 1910, she took a postgraduate course at the Great Ormond St. Hospital for Children in London, England. She had a large practice and was active in all civic and church work. She had the first electric automobile. Her bicycle was the most used until they went out of style, then autos followed. She retired in 1946. She is the only living doctor among those doctors who were practicing in Gallipolis when she began to practice in 1894.

EPIDEMICS

The first recorded epidemic was in 1793 three years after the settlement of Gallipolis and no doubt Dr. Saugrain was the physician at that time. This was a severe epidemic, resembling yellow fever. Seventeen persons died. Many of the settlers left after this to go to more civilized parts and to the French Grant. In a clipping taken from our daily paper, *The Tribune*, of November 15, 1897, appeared a reprint saying, "the first expidemic of yellow fever that ever occurred in the United States, was at Gallipolis, Ohio, in 1793, brought there by a party of immigrants from Spain who had landed at Baltimore."

An epidemic of smallpox in 1872 was not very severe. Patients were isolated in a pest house outside of the city. Dr. James Johnson took charge of it.

In 1878 a steamboat from New Orleans going to Pittsburg was forced to stop here because of a broken shaft. Many persons visited the boat, and in a few days the epidemic of yellow fever began. Dr. William C. H. Needham, who graduated from Johns Hopkins University School of Medicine and located in Gallipolis in 1868, was the City Physician who had charge of the quarantine of the boat and approaches. Burning pots of tar were used as disinfection. Asepsis was not in use then as it is today. Sixty-six people died. Dr. Needham was elected as Senator in 1884 and died in 1885.

Dr. Samuel Kerr, born 1824, assisted Dr. Needham and Dr. Fred Cromley during Yellow Fever Epidemic as head of the pest-house, outside of the city. It is said "he had seven wives."

The influenza was an epidemic in 1915 and 1917. Many doctors were off duty for a week or more at a time because of their own illness. Many deaths occurred especially among the old. The expidemic of 1917 was not as severe as 1915.

Only sporadic cases of typhoid fever have been prevalent and the source could almost always be traced outside of our city. Water in and around the county has been of the purest. We have never had a real epidemic of diphtheria.

EPILEPTIC HOSPITAL

In his inaugural address, Governor James E. Campbell urged the construction of a separate institution for Ohio's epileptics and in 1890 the General Assembly enacted such a law. In August, 1890, Gallipolis was chosen as the site for the Ohio Hospital for Epileptics now called Gallipolis State Institute. The first corner stone was laid November 12, 1891. It was then the only one of its kind in the United States on the cottage plan.

Dr. H. C. Rutter was appointed the first superintendent from 1893 to 1901. The first patient was admitted November 3, 1893. Dr. W. K. Coleman followed Dr. Rutter from 1901 to 1902, and was succeeded by Dr. A. P. Ohlamacher who served from 1902 to 1905. Dr. W. B. Pritchard served from 1905 to 1911, when Dr. G. G. Kineon succeeded him from 1911 until his death, August 21, 1943. Dr. John G. Schwartz was then superintendent from 1943 to 1944. Dr. George R. Roberts is the present superintendent, a very capable, tactful and kind man. This has been a wonderful institution. Many fine members of the staff served the constantly increasing number of patients, keeping up with the new treatments being brought forth. New buildings are still being added as needed appropriations are allowed. Among the staff who served many years are the following: Dr. Mary L. Austin was on the staff of the Hospital thirty years, graduated from Ohio University Medical College, 1904, died 1947. She was a very efficient and useful member. Dr. G. G. Kineon was on the staff of hospital from 1906 to 1911, when he became superintendent after Dr. Pritchard resigned to enter general practice in Gallipolis. He was not only a brilliant physician and a superb administrator, but he had a wonderful knowledge about farming, fruit growing, flora, business, civic and social affairs. His death was a great loss to the state as well as to the community in which he lived.

Dr. John G. Schwartz graduated from Medical College of Ohio, Cincinnati, in 1912. He was a member of the staff of the Ohio Hospital for Epileptics from 1912 to 1943, when he became superintendent following the death of Dr. G. G. Kineon. His death, April 1, 1945, brought sorrow to his many friends and associates.

Dr. S. L. Bossard has been a loyal and faithful staff member since 1920. He graduated from the Loyola University School of Medicine, Chicago.

DR. HOLZER HOSPITAL

After completing a surgical residency at the Ohio Hospital for Epileptics, Dr. Charles E.

Holzer, Sr., saw the need of a hospital in Gallipolis. The Holzer Hospital was established in 1910 by him. Financed on borrowed money, the first hospital was a remodeled residence, which accommodated only eight beds. In 1913, he spent a year in postgraduate study in Europe. In 1917 the first wing of the present Holzer Hospital, a four-story brick building, was built. A few months after this he enlisted in the Medical Corps of the Army and the hospital was closed until the end of the World War I. As it was needed, a unit at a time was built. The hospital is now air-conditioned and has unusually complete equipment. A school of nursing was established in 1920 with only a few pupils. Now in 1949, it has graduated 300 nurses. It is fully accredited by the Ohio State Nurses' Board. Gallipolis today enjoys recognition as a rapidly growing medical center, the heart of which is this outstanding hospital. Its capacity now is seventy-five beds and twelve bassinets. Six doctors are on the staff and devote all their time to it and the clinic. All have had years of training and experience in their specialities. Gallipolis is fortunate in having such excellently trained specialists and general practitioners outside of the hospital staff.

Registered medical technologists with radiologist, pharmacist and dietitian are on duty. The larger part of the work is surgical, owing to the many surgical cases and limitation of room. The personnel of the hospital consists of 120 persons besides the 52 student nurses. The large proportion of the patients come from a distance as the reputation of the hospital has gone far beyond the borders of Gallia County. Many wished to see the hospital serving the people in southern Ohio in perpetuity and with this thought in mind, The Holzer Hospital Foundation, a non-profit corporation, was founded in 1929, the purpose of which has been to receive gifts and eventually take over the operation of the hospital.

Dr. and Mrs. Holzer gave the hospital and equipment to the Foundation in May, 1948, as they wished to be able to help the new regime to get under way rather than wait to turn over the property after their deaths. Since January 1, 1949, the Holzer Hospital is no longer a private institution, but is operated by the foundation, employing the same personnel, and giving the same service as in the past.

Dr. Charles E. Holzer, Jr., joined the staff three years ago and is now head of the surgical unit.

Following are the members on the staff of the Holzer Hospital: Dr. Charles E. Holzer, Jr.; Dr. Otto A. Vornholt; Dr. Paul C. Foster; Dr. Calvus Elton Richards; Dr. Jacob Weinberger; and Dr. Marcus J. Magnussen.

GALLIPOLIS CLINIC

Gallipolis Clinic became a reality November 19, 1939, for the purpose of giving better service to the people by combining the facilities of three different physicians: Drs. Leo C. Bean, Norvil A. Martin and Homer B. Thomas. It was organized as a private enterprise. All modern equipment was installed even to elevator service.

CANCER CLINIC

Gallia County's new "cancer detection center" officially launched its career February 17, 1949, when the first patient was examined.

A clinic is held once every two weeks in the Holzer Hospital with Dr. Jacob Weinberger as head. A complete examination is made by a staff of competent physicians upon twenty or more persons, some coming from different cities and states, who are becoming "cancer-minded." This is one of the best educational projects so far—"early detection of cancer."

A campaign for funds is now on. It is one of only a few clinics in the State of Ohio. It is purely a diagnostic detection cancer clinic.

TRANSPORTATION

The great improvement of roads has made transportation much easier and time-saving than when doctors had to make their calls on foot or horseback. As roads were improved, buggies, run-abouts, bicycles, and automobiles came in use. The first automobiles were very crude and slow running, frightening to horses and amazing to many people. Fifty years have changed them into luxurious traveling. In the midst of this luxury, we are becoming plane-minded. With the increase of autos, came a decrease of rural doctors. Patients would pass their rural doctors during the day to go to a city doctor, but at night, call their rural doctor. Many of these doctors have had to leave and seek other locations. There is not one rural practicing physician now in Gallia County, therefore, Gallipolis is the medical center.

Because of the increase of drugs (some increasing as much as 200 per cent) instruments and other supplies, the medical profession, February, 1942, felt justified in formulating a new, increased fee schedule.

"The remarkable progress of medicine generally in the course of over one-hundred fifty years has been reflected in the medical practice of Gallipolis. In earlier years physicians then made up their own drugs, while bleeding by wrist-cutting or leeches was a panacea for almost any ailment, but now medicine has shifted from conjecture to science. Our facilities, with the hospital and clinic, are as good as those of any county in the state, and our men are as well trained in postgraduate courses and special clinics as can be found anywhere."

Proceedings of The Council . . .

Machinery Is Set Up for Collection of A. M. A. Dues; 1950 Budget Is Approved; Other Important Business Transacted at Dec. Meeting

THE Council of the Ohio State Medical Association met in the State Headquarters Office, Columbus, on Sunday, December 18, 1949, with the following in attendance: President Lincke, President-Elect Swartz, Treasurer Worstell; Councilors Heusinkveld, Prugh, Mundy, Dixon, Davis, Foster, Swett, Clodfelter, and Hattery; Mr. Charles H. Coghlan, Executive Vice-President of Ohio Medical Indemnity, Inc., and Secretaries Nelson, Saville, Page and Moore.

After calling the meeting to order, Dr. Lincke, the President, took up with The Council the question of making some replacements on several committees.

Dr. Lincke appointed as a member of the Subcommittee on Legislation, Dr. Wm. J. Graf, Cincinnati, to succeed Dr. Emil R. Swepston, who has left Ohio, and Dr. James B. Johnson, Jr., Newark, to succeed Dr. R. G. Plummer, Newark, resigned.

He announced the appointment of Dr. Charles F. Good, Cleveland, as a member of the Committee on School Health, and Dr. Herbert B. Wright, Cleveland, as a member of the Committee on National Emergency Medical Service.

TO ANALYZE CHILD HEALTH STUDY

Dr. Lincke stated that he felt the Committee on Education would be the proper committee to make an analysis of the recent report on child health services in Ohio, made by the Ohio branch of the American Academy of Pediatrics. This met with the approval of The Council and Dr. Lincke designated the Committee on Education to carry on this study. He named Dr. James G. Kramer, Akron, and Dr. Benjamin Hoyer, Cincinnati, as special consultants to the committee on this question.

The foregoing appointments were approved by The Council on **motion** duly made, seconded, and unanimously **carried.**

The minutes of the meetings of The Council held on September 17-18, 1949, at the Granville Inn, Granville, **were approved** on **motion** duly made, seconded, and unanimously **carried.**

MEMBERSHIP AT ALL-TIME HIGH

The Executive Secretary reported membership statistics as follows: Total membership as of December 15, 1949, 7,473, an all-time record, including 11 military members for whom dues are waived; compared to a total membership of 7,331 as of December 31, 1948.

On **motion** duly made, seconded, and unanimously **carried,** The Council authorized continuance of the policy of waiving State Association dues during 1950 for physicians serving temporarily in the Armed Forces, having been deferred from military service in order to complete their medical education.

The question of how to assess dues for members who leave Ohio to establish a practice in another state and then return to Ohio and reaffiliate, was raised by the Executive Secretary and the advice of The Council requested. On **motion** duly made, seconded, and unanimously **carried,** the following resolution was adopted:

> "When a member of the Ohio State Medical Association leaves Ohio to establish a practice in another state and ceases to be a member of this Association but later returns to Ohio to practice and becomes a member of a component county medical society, he shall be regarded as a new member of the Ohio State Medical Association and shall be assessed the current dues being charged new members."

Members of The Council then reported on activities among the county medical societies in their district.

BUDGET FOR 1950 ADOPTED

The Council then went into executive session for the purpose of reviewing the finances of the Association, hearing a report from the Committee on Auditing and Appropriations and adopting a budget for the calendar year 1950.

The following recommendations of the Auditing and Appropriations Committee were adopted on **motion** duly made, seconded, and **carried:** Purchase of a new mimeograph and a postage meter machine; acceptance of the bid of Stoneman Press for printing *The Journal* in 1950 at a four per cent increase; payment by the State Association of the base premiums in Blue Cross and Ohio Medical Indemnity for all employees; employment of one new full-time clerical employee; presentation of a Christmas bonus to all employees.

With respect to the bonuses for employees, the following resolution was adopted:

> "In appreciation of our employees' sincerity and loyalty, it is **moved** by Dr. Dixon, seconded by Dr. Mundy, and **carried,** that all permanent employees be paid one month's salary as a Christmas bonus, and that all part-time employees be paid $50.00 each. The payment of this bonus should not be construed as the establishment of a bonus precedent for future years."

On **motion** duly made, seconded, and **carried,** The Council adopted the following budget for 1950:

The Ohio State Medical Journal		$20,000.00
Executive Secretary, Salary		10,000.00
Executive Secretary, Expense		1,500.00
Stenographic-Clerical Salaries		16,000.00
President's Expense		1,000.00
Council, Expense		2,500.00
A. M. A. Delegates, Expense		4,000.00
Department of Public Relations (see below)		33,100.00
Director, Salary	$ 8,500.00	
Director, Expense	1,500.00	
Asst. Director, Salary	4,800.00	
Asst. Director, Expense	800.00	
Exhibits and Newspaper Publicity	2,000.00	
Literature	10,000.00	
Postage	2,500.00	
Supplies	500.00	
Speakers' Bureau	500.00	
Miscellaneous Expense	2,000.00	
Committee on Education		500.00
Committee on Public Relations and Economics		500.00
Committee on Scientific Work		800.00
Committee on Auditing and Appropriations		200.00
Committee on Cancer		500.00
Committee on Industrial Health		500.00
Committee on Medical Care of Veterans		200.00
Committee on Medical Service Plans		200.00
Committee on National Emergency Medical Service		300.00
Committee on Rural Health		1,500.00
Rural Medical Scholarship		1,000.00
Committee on School Health		800.00
Miscellaneous Committees		200.00
Annual Meeting		16,000.00
Conference County Society Presidents-Secretaries		2,000.00
Postage		1,500.00
Telephone and Telegraph		1,500.00
Professional Relations Activities		4,500.00
Rent		7,350.75
Insurance and Bonding		900.00
Stationery and Supplies		2,500.00
Employees' Retirement Fund		2,550.00
Contingent Unassigned		11,142.58
Total		$145,243.33

ACTION OF OHIO MEDICAL APPROVED

Upon re-convening in regular session, The Council then considered a resolution adopted by the Board of Directors of Ohio Medical Indemnity, Inc., on December 14, 1949, reading as follows:

"Resolved, that Ohio Medical Indemnity, Inc., subscribe $25,000 to Associated Medical Care Plans as a furtherance of its interests in national enrollment and in accordance with a Contribution Agreement; that the executive officers be authorized to execute and deliver said Contribution Agreement to Associated Medical Care Plans; that this subscription be subject to the approval of the shareholders of Ohio Medical Indemnity, Inc."

The Council, on behalf of the Ohio State Medical Association, a shareholder in Ohio Medical Indemnity, Inc., approved the action of the Board of Directors of Ohio Medical Indemnity in authorizing a subscription not to exceed $25,000 to Associated Medical Care Plans and authorized the Executive Secretary, on behalf of the Ohio State Medical Association, to sign legal documents which might be required of shareholders of Ohio Medical for the purpose of completing this transaction.

Mr. Charles H. Coghlan, Executive Vice-President of Ohio Medical Indemnity, who had been invited to participate in the discussion of this question, reported that Ohio Medical anticipates a total of 700,000 subscribers by the end of 1949. Mr. Coghlan also reported that the solicitation by Ohio Medical Indemnity of so-called "pay direct" subscribers to Blue Cross in the Cincinnati area had resulted in the addition of approximately 40,000 new subscribers to Ohio Medical. Also, he reported that new community enrollments would be conducted during 1950 and that considerable progress is being made in the enrollment of farm groups.

DATES FOR CONFERENCES SELECTED

The Council selected Sunday, March 5, as the date for the annual conference of county society presidents, secretaries and committeemen, and Tuesday, March 14, as the date for a conference of officers and committeemen of local auxiliaries. On **motion** duly made, seconded, and unanimously **carried,** it was decided that these conferences should be held at the Fort Hayes Hotel, Columbus, and that the Executive Secretary should proceed to arrange for suitable programs for such meetings.

DISABILITY INSURANCE DISCUSSED

The Executive Secretary reported to The Council regarding the activities of a special legislative commission established by the Ohio General Assembly to study the question of setting up in Ohio a temporary disability insurance program similar to the unemployment compensation program. Also, he reported on a conference he had attended at the A. M. A. Headquarters in Chicago in November on this question. On **motion** duly made, seconded, and unanimously **carried,** the President was authorized to designate the Committee on Industrial Health and Workmen's Compensation to handle this question on behalf of the Ohio State Medical Association and to appoint special consultants to that committee, if deemed advisable.

In a second **motion**, which was **carried** unanimously, the President was authorized to name one or more representatives from the Ohio State Medical Association to participate in deliberations of a special committee on temporary disability insurance being established by the Ohio Citizens Council for Health and Welfare, 135 East Gay Street, Columbus.

On behalf of the Committee on Scientific Work, the Executive Secretary submitted a report on the progress to date in setting up the 1950 Annual Meeting program. On **motion** duly made, seconded, and unanimously **carried,** the actions of the committee were approved.

There was a discussion of the argument taking place in Washington as a result of the action of the Director of the Budget in disapproving free medical and hospital care for dependents of military personnel within the continental limits of the United States. It was the opinion of

The Council that it should take no action on this question at this time.

FEDERAL LEGISLATION

Communications from the American Medical Association, pointing out that the House of Delegates of the A. M. A., in session in Washington, D. C., in December, had disapproved the following Federal bills in their present form, were read and discussed: S. 1411, the so-called School Health Services Act; S. 1453, proposing Federal aid to medical education.

On **motion** duly made, seconded and unanimously **carried,** the action of the House of Delegates of the A. M. A. was endorsed by The Council.

It was pointed out that S. 1411 had been disapproved because it contained a provision whereby all school children, regardless of the financial status of their parents, would be beneficiaries and that S. 1453 had been disapproved because it does not in its present form guarantee academic freedom of medical schools which would receive Federal financial aid.

VETERANS ADMINISTRATION

A regulation of the Veterans Administration prohibiting dual appointments thus preventing physicians employed on a part-time basis from participating in the fee-for-service program, was discussed. This had been discussed at the last meeting of The Council and left pending. Advice from the regional offices of the Veterans Administration in Ohio indicated that there were no new developments and that the regulation is still in effect. On **motion** duly made, seconded, and unanimously **carried** the Executive Secretary was instructed to write the National Director of the Veterans Administration, Washington, for the purpose of securing the reasons for the enactment of the regulation.

Dr. Lincke and others gave reports on the recent session of the House of Delegates of the A. M. A. held in Washington, D. C.

COLLECTION OF A. M. A. DUES

The Council, on **motion** duly made, seconded, and unanimously **carried,** endorsed the action of the House of Delegates in providing for the collection of $25.00 A. M. A. membership dues in 1950.

Establishment of the procedure for the collection of the A. M. A. membership dues in Ohio was then discussed and the following procedure adopted, on **motion** duly made, seconded, and unanimously **carried:**

1. Notification regarding the A. M. A. membership dues shall be sent immediately to the secretaries of all county medical societies.

2. A letter from President Lincke shall be sent to all members of the Ohio State Medical Association at the time 1950 membership cards are mailed to members.

3. The letter referred to shall explain in detail the action of the House of Delegates of the A. M. A. and the reasons for the dues.

4. The letter from Dr. Lincke shall be accompanied by a return, postage-paid envelope which can be used by the physician in transmitting his check for $25.00 for A. M. A. dues to the Columbus office.

5. All money collected for A. M. A. dues shall be banked in the account of the Ohio State Medical Association.

6. Periodic lump sum payments shall be made by the Columbus office to the Chicago office of the A. M. A. and shall be accompanied by a list of those paying the dues.

7. Lists of physicians paying A. M. A. membership dues shall be sent periodically to county society secretaries for their information and records.

8. After a reasonable time lists of unpaid members shall be sent to the secretaries of local medical societies with a request that they contact physicians who have not paid their A. M. A. dues and collect such dues for transmissal to the Columbus office.

The Executive Secretary submitted a statistical report on the collection of the 1949 special assessment of $25.00, showing that as of December 1, 4,886 members of the Ohio State Medical Association had paid the assessment, representing approximately 65 per cent of the total membership of the Association as of that date.

50-YEAR AWARDS

Members of The Council reported on the awarding of the 50-year emblems and certificates, most of them indicating that the awards had been made in a majority of the county medical societies in their districts. All members of The Council stated that in their opinion this had resulted in an excellent public relations program and that the ceremonies in most counties had received widespread favorable newspaper publicity. On **motion** duly made, seconded, and unanimously **carried,** The Council expressed itself as believing that this project should be continued annually as one of the major Fall activities of the Association.

AMENDMENTS APPROVED

The Council then considered actions taken by several county medical societies in amending their constitutions and by-laws.

An amendment adopted by the Darke County Medical Society at a meeting on November 15, 1949, and a proposed amendment by that society to increase local dues, were approved on **motion** duly made, seconded, and unanimously **carried**

A revised constitution and by-laws adopted by the Richland County Medical Society on November 17, 1949, was **approved** on **motion** duly made, seconded, and unanimously **carried.**

However, the wording of Section 6, Chapter 4 of the by-laws, particularly the last sentence of Section 6, was questioned by several members of The Council as being an unworkable provision. The matter was referred to Dr. Hattery, Councilor of the Eleventh District, with a suggestion that he confer with the Richland County Medical Society on the matter of re-wording the section.

The Stark County Medical Society had asked for advice regarding a proposed amendment which would provide that associate membership could be extended to physicians who are unable to pay dues because of illness or misfortune. The Council could take no official action on this question as the question had not been submitted in regular form, but indicated that the amendment would be approved when properly submitted.

MISCELLANEOUS BUSINESS

A communication from the chairman of the Goiter Study Committee of the American Public Health Association, asking the Ohio State Medical Association to endorse, sponsor and cooperate in the enactment of a bill requiring that all salt sold in the State of Ohio shall be iodized, was read and discussed. On **motion** duly made, seconded, and unanimously **carried,** the matter was tabled pending further study.

On **motion** duly made, seconded, and unanimously **carried,** the payment of $50.00 in dues for 1950 to the Conference of Presidents and Other Officers of State Medical Associations, was authorized.

A communication from Mr. A. R. Kaiser, General Manager of the Tax Department of Sears, Roebuck and Company, Chicago, regarding the activities of the Research Council for Economic Security, was read and discussed. On **motion** duly made, seconded, and unanimously **carried,** a contribution of $100.00 to the organization was authorized.

A communication from the National Tax Equality Association dated October 27, 1949, asking for the help of the Ohio State Medical Association in contacting members of the Congress, was read and discussed. On **motion** duly made, seconded, and unanimously **carried,** The Council decided that no action should be taken on this request at this time.

A communication, suggesting that the Ohio State Medical Association establish a Committee on Chronic Illness, was read and discussed. On **motion** duly made, seconded, and unanimously **carried,** the President was authorized to appoint such a committee.

A proposal from an organization, asking permission to microfilm issues of *The Ohio State Medical Journal* for sale to libraries, and proposing a small commission to the Association for extending such rights, as well as copies of all microfilms produced, was discussed. On **motion** duly made, seconded, and unanimously **carried,** the proposition was referred to the Executive Secretary for final decision after securing additional information on the proposal.

There was a discussion of the plan of the Ohio Commission on Children and Youth to establish local units in each county. It was pointed out that several officials of the Ohio State Medical Association are serving on advisory or executive committees of this commission. The Council expressed itself as believing that the local units should not be sponsored by the county society, but that the county medical society should have representation on such local committees in order to properly advise and guide such local committees in their activities.

A communication from a Dayton physician raising a question about the method used by one Dayton hospital in handling cases involving recipients of aid for the aged was read and discussed. On **motion** duly made, seconded, and unanimously **carried,** the Montgomery County Medical Society was requested to make a thorough investigation of this question and submit a report to The Council at an early date.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

American College of Allergists

Several Ohio doctors took leading parts in the Annual Meeting of the American College of Allergists in St. Louis, January 16-18.

Dr. John H. Mitchell, Columbus, assumed office as president of the College for the coming year. He also read a paper entitled, "Blood Eosinophile Fluctuations During Constitutional Reactions." This was in cooperation with Dr. Jesse Gamble of Houston, Tex.

Dr. Jonathan Forman, Columbus, Editor of *The Journal,* delivered the presidential address on January 17. At that time he had the honor of presenting the Von Piquet medal to Dr. S. S. Kallos of Sweden. After the presentation, he relinquished the presidency to Dr. Mitchell.

Dr. Hermann Blatt, Cincinnati, read a paper entitled, "The Role of Bacterial Allergy in the Rheumatoid State."

Dr. Frank A. Nantz, also of Cincinnati, read a paper entitled, "Hypersensitivity Versus Immunity to Streptococci."

Dr. George E. Rockwell, Milford Center, immediate past-president of the College, took part in a panel discussion.

Dr. S. William Simon, Dayton, read a paper, "Hypo-Allergic Penicillin." Dr. L. E. Seyler, also of Dayton, opened discussion on Dr. Simon's paper.

EXPLANATION OF AMERICAN MEDICAL ASSOCIATION MEMBERSHIP DUES AND HOW TO PAY THEM

FOLLOWING is the text of a letter over the signature of Dr. Carl A. Lincke, President of the Ohio State Medical Association, **which is being sent to each member when his 1950 Ohio State Medical Association membership card is mailed to him** from the Columbus Office. State Association membership cards (and the letter) are mailed after dues are received from the County Society secretary-treasurer. **Cards are mailed as promptly as the checks and lists from local secretaries can be processed.** Checks for A. M. A. membership dues are rolling into the Columbus Office daily and the dues will be transmitted in lump sum periodically to the A. M. A. in Chicago.

* * *

Dear Doctor:

Enclosed is your 1950 membership card in the Ohio State Medical Association. Preserve it carefully, especially for use in registering at the 1950 Annual Meeting, next May 16-18, Cleveland, Ohio.

Also, enclosed is an envelope which you can use in transmitting your check for **1950 American Medical Association membership dues of $25.00.**

For the first time in its history, the American Medical Association will charge membership dues in 1950. Action calling for the payment of membership dues was taken by the House of Delegates meeting in Washington, D. C., on December 6, 1949. This was in compliance with a provision of the Constitution and By-Laws of the A. M. A. but which had never been enforced. Reasons for this action were enumerated in the following statement, submitted to and endorsed by the House of Delegates:

"The responsibilities of the American Medical Association are increasing constantly and the revenues of its publications can no longer meet the costs of its broadening program. The American Medical Association recognizes the greatly augmented activities of the constituent associations and of the component medical societies. However, it is aware of its own responsibility in providing aggressive, effective leadership for the medical profession on a national level. This leadership includes constructive assistance in building and improving the many splendid voluntary health insurance systems, so that all who desire or need prepaid medical care may be provided with it, without political controls or compulsion.

"The American Medical Association, like other great national organizations, must depend on dues from its membership to support its growing program of service, both to the profession and to the public."

A physician delinquent in the payment of A. M. A. membership dues will lose his membership in the A. M. A. To secure reinstatement he will have to pay accrued indebtedness.

There is no change with respect to A. M. A. Fellowship. To be a Fellow, a physician must first be a member in good standing. Fellowship dues remain at $12.00 per year. As a Fellow, a physician receives *The A. M. A. Journal;* can participate in the A. M. A. program; and is eligible to be a delegate, officer or committeeman of the A. M. A. In the future, all members in good standing of the A. M. A. will be privileged to attend all sessions of the A. M. A. In the past, only Fellows could attend.

Collection of the $25.00 A. M. A. membership dues was delegated to the state and local medical societies. **Our Columbus Office will transmit these dues on your behalf to the Chicago Office of the A. M. A. You will receive a membership card and membership certificate direct from the A. M. A. office.**

If you will pay your A. M. A. membership dues of $25.00 direct to our Columbus Office, you will greatly assist and expedite the collection in Ohio. Local Secretary-Treasurers will not be burdened in the first instance with this job. However, later they will be requested to contact those who may be delinquent in payment of dues.

The Council of the Ohio State Medical Association, meeting on December 18, endorsed the action of the A. M. A. House of Delegates and established this procedure for the collection of the A. M. A. dues. The Council earnestly solicits your prompt cooperation.

Sincerely yours,

Carl A. Lincke, M. D.

President.

Scene of the 1950 Annual Meeting . . .

The Spacious Cleveland Public Auditorium Will Be the Center of Activities For Ohio's Number One Meeting of the Year, May 16-18



cientific Assemblies

Instructional Courses

Medical Topics of the Day

National Affairs

Scientific Exhibits

Technical Exhibits

Auxiliary Annual Meeting

Annual Banquet

SEE FACING PAGE FOR DETAILS

Features of the 1950 Annual Meeting . . .

The Most Comprehensive Scientific Program of the Year Is Planned To Furnish Postgraduate Work for Doctors in All Branches of Medicine

THREE Red Letter days are on the doctors' calendar—Tuesday, Wednesday and Thursday, May 16, 17 and 18—dates of the 1950 Annual Meeting of the Ohio State Medical Association in Cleveland.

General Sessions—Scientific programs are being sponsored by each of the Specialty Sections and will be presented before General Sessions to the interest of physicians in all branches of medicine. This procedure is a change from the previous practice of having Specialty Sections present their programs before their respective specialty members only. The new procedure is designed to give all doctors an opportunity to benefit from the experiences of the specialists in their respective fields. Out-of-state guest speakers as well as Ohio physicians will participate.

Instructional Courses will be conducted in the manner found so effective in the last several meetings. Eighteen courses will be conducted. They will be scheduled so that each physician can choose at least three courses in which he is most interested. These courses, conducted on a question-and-discussion basis, have drawn a great deal of interest in previous meetings. A full list of subjects to be discussed will be announced in a subsequent issue of *The Journal* and in a program resumé which will be mailed to all members. Instructional Courses are limited to comparatively small groups which lend themselves to informality, and admission will be by ticket only. Members will be advised later on how to obtain tickets.

Medical Topics of the Day—Here again doctors will have a choice of several discussions going on at the same time. This type of information program was instituted at last year's meeting where it proved very effective. These programs are conducted on a slightly more formal basis than the Instructional Courses, but get away from the scientific paper presentation procedure. Picked authorities carry on an unrehearsed panel discussion for the benefit of attending doctors. Clinical procedures will be emphasized.

National Affairs — Two out-standing guest speakers will appear on the program for the purpose of discussing national affairs. One will be United States Senator Robert A. Taft of Ohio who will talk on pending legislative proposals and vital national problems. The other will be Dr. George F. Lull, secretary and general manager of the American Medical Association, who will talk about the National Education Program of the A. M. A. and other activities of the national medical association. They will speak at a General Session on Wednesday morning, May 17.

Scientific Exhibits—These exhibits which feature latest developments in medical research and investigation have become a major feature of the Annual Meetings. This year all exhibits will be in the spacious Public Auditorium where visitors may take advantage of almost unlimited space to study exhibits and discuss them with the sponsors.

Technical Exhibits—As usual an interesting feature of the meeting will be the commercial exhibits of pharmaceutical and other supply houses which have always proved a main educational feature. These exhibits give doctors an opportunity to observe the latest drugs, surgical instruments, etc., on the market and to discuss their merits with firm representatives.

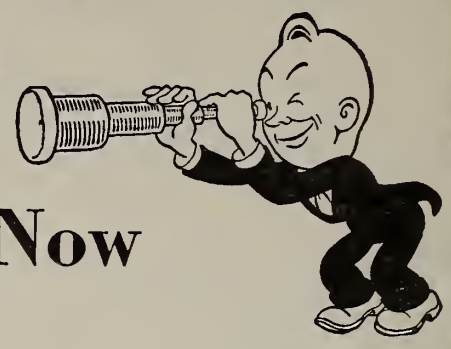
House of Delegates—The legislative body of the Association will meet twice during the Annual Meeting to formulate policies and transact other business. These meetings will be held at the Hotel Cleveland.

Auxiliary—The Woman's Auxiliary of the Ohio State Medical Association will hold its annual meeting concurrently with the Annual Meeting of the Association. More details will be given as arrangements are completed.

Annual Banquet—Wednesday evening, May 17, again has been reserved for the main social function of the Annual Meeting. The banquet will be followed by an evening of entertainment and dancing. No speeches.

Registration—There is no registration fee for any of the scientific programs. Information will be sent out to members on how to make reservations for Instructional Courses. Since the Banquet is essentially a social function, a nominal amount will be charged for dinner and entertainment.

Are You Looking Ahead?



Make Hotel Reservations Now

for the

1950 Annual Meeting

Ohio State Medical Association

Cleveland, Ohio . . . May 16, 17, 18

NAME AND LOCATION	SINGLE	DOUBLE	DOUBLE TWIN BED
ALLERTON HOTEL, 1802 E. 13th St.	$3.50-6.50	$5.50-10.00	$6.00-10.00
AUDITORIUM HOTEL, 1315 E. Sixth St.	$3.50-3.75 $4.50-5.00	$5.50-6.00 $7.00	$7.50 and Up
CARTER HOTEL, PUBLIC SQUARE	$4.75-7.00	$7.00-10.00	$8.00-12.00
CLEVELAND HOTEL (Headquarters Hotel)	$4.50	$6.50-9.00	$9.00-14.00
HOLLENDEN HOTEL, 610 Superior Ave.	$3.50-8.00	$5.50-10.00	$7.00-14.00
OLMSTEAD HOTEL, Superior & E. Ninth	$3.00-6.00	$5.00-8.00 $7.00-9.50	$7.00-9.50
STATLER HOTEL, Euclid at E. 12th St.	$4.00-6.00	$7.00-10.00	$8.00-12.00

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Hotel, Cleveland, Ohio

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 16, 17, 18, 1950, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Suite

Arriving May.....at.....A. M.....P. M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

.....

On the Congressional Front . . .

Messages of President Indicate He Is Still Pressing for Compulsory Health Plan; Huge Expenditures for "Welfare State" Asked in Budget

IN his recent State-of-the-Union message to the Congress and in the message which accompanied his proposed Federal Budget for the next fiscal year, President Truman made it clear that he is not retreating from his stand in favor of compulsory health insurance and an inflated "welfare state" program.

Using soft words, but words carrying far-reaching implications, the President made these comments regarding social security and health in his State-of-the-Union message:

> "Our social security system should be developed into the main reliance of our people for basic protection against the economic hazards of old-age, unemployment, and illness. I earnestly hope that the Congress will complete action at this session on legislation to increase the benefits and extend the coverage of old-age and survivors insurance. The widespread movement to provide pensions in private industry dramatizes the need for improvements in the public insurance system.
>
> "I also urge that the Congress strengthen our unemployment compensation law to meet present-day needs more adequately. The economic downturn of the past year was the first real test that our system of unemployment insurance has had to meet. That test has proved the wisdom of the system, but it has also made strikingly apparent the need for improving its operation and increasing its coverage and its benefits.
>
> "In the field of health, there are immense opportunities to extend to more of our people the benefits of the amazing advances in medical science. We have made a good beginning in expanding our hospitals, but we must go on to remedy the shortages of doctors, nurses, and public health services, and to establish a system of medical insurance which will enable all Americans to afford good medical care."

"SKY'S THE LIMIT"

In his Budget Message, Mr. Truman was more specific, even recommending a definite payroll tax "to defray initial expenses" of a national health insurance scheme. Following are certain significant passages from the message:

NATIONAL COMPULSORY HEALTH INSURANCE

"I again strongly urge the adoption of legislation providing for a comprehensive system of prepaid medical care insurance. This should be geared in with our other social insurance programs and financed predominantly by employer and employee contributions."

OLD-AGE AND SURVIVORS INSURANCE

"I urge that the Congress enact legislation to expand and improve the old-age and survivors insurance system . . . Specifically, nearly all gainfully employed people, including farmers and the self-employed, should be covered; benefits should be increased sharply; and disability should be added to the risks covered. It is also important that the tax base be raised to the first 4,800 dollars of earned income . . . Only 1,900,000 aged persons received insurance benefits and 800,000 children and their mothers receive survivors benefits under the old-age and survivors insurance system."

DISABILITY INSURANCE

"Public demand for some form of basic financial protection against loss of earning power is evident in the keen interest of wage earners in industrial pension and insurance plans. What I wish to emphasize is that the basic approach should be through a comprehensive public program . . . rather than through a multiplicity of unrelated private plans, which would inevitably omit large numbers of the working population and treat others unequally."

PUBLIC ASSISTANCE

"I therefore renew my recommendation of last year that the program of Federal grants to States for public assistance be extended and improved. Approximately 2,700,000 aged people and 1,500,000 dependent children now receive public assistance."

PUBLIC HEALTH AND HOSPITALS

"Federal expenditures for public health are mainly for grants-in-aid to states and for research. Of the 334 million dollars estimated for existing programs in the fiscal year 1951, 213 million dollars is for financial assistance to the states for general public health services and for a wide variety of special state and local programs, including hospital construction, maternal and child health, tuberculosis control, and mental health. The increase of 75 million dollars in expenditures over 1950 for existing programs is caused largely by a rise in grants to liquidate prior years' hospital construction authorizations. This program is helping communities throughout the Nation to reduce the hospital shortage."

LOCAL PUBLIC HEALTH UNITS

"I hope that Congress will soon complete action on legislation to increase Federal assistance to local health services."

FEDERAL ASSISTANCE TO MEDICAL EDUCATION

"Legislation should be enacted to provide financial aid to medical and related schools to

encourage the training of additional medical personnel. In the case of nurses, tuition scholarships and subsistence aids should be made available for training graduate nurses, and grants should be made to States for vocational education for practical nurses, to encourage more young women to enter the profession."

WELFARE DEPARTMENT

"I recommend again that the Federal Security Agency be given departmental status; its functions are so important to the domestic policies of the Government that the head of this Agency should be a member of the President's Cabinet."

VOCATIONAL REHABILITATION

"I am also proposing legislation to strengthen the Federal-State program of vocational rehabilitation and to provide additional opportunities for rehabilitation of the more severely handicapped. The Budget includes 4 million dollars for the first year under the proposed legislation."

COST OF SOCIAL WELFARE, HEALTH AND SECURITY PROGRAM

"These items plus increases under existing legislation in these two fields, are expected to cause Budget expenditures for social welfare, health, and security to rise in the fiscal year 1951 to a level of 2.7 billion dollars, an increase of 417 million dollars over the current year."

NOTE: The figure 2.7 billion dollars is shown as $2,790,216,652. The inclusion of costs of security in the above grouping represents only administrative costs—payroll deduction figures are nowhere represented in this Budget.

VETERANS HOSPITALS

"Construction of hospitals to provide 37,000 new beds and additional domiciliary facilities, costing 872 million dollars, is now about one-third completed. When this program is finished, there will be sufficient beds to provide adequately for foreseeable needs for all service-connected cases and a more liberal allowance of beds than at present for non-service-connected cases. Obligational authority already available is more than adequate to meet the needs of the program now under way. Current expenses for hospital and medical care are estimated at 590 million dollars in the fiscal year 1951. About four-fifths of these expenditures are for the in-patient care program, and in this program two-thirds of the cases currently are non-service-connected. A daily average of 138,000 patients in hospitals and homes is estimated for 1951, about 9,000 more than were cared for in 1949 and 4,000 more than in the current year. The other one-fifth of the expenditures is largely for the out-patient medical and dental care programs."

ALL COSTS NOT INCLUDED

Those who have analyzed the Truman budget point out that the entire cost of proposed legislation to expand the Social Security Program is not included in the budget. On this point the budget message comments as follows:

> "Under the old-age and survivors insurance, railroad retirement, and Federal employee retirement programs, benefit disbursements are made from the trust funds and are not included in Budget expenditures. On the receipts side, the payroll contributions for old-age and survivors insurance are transferred directly to the trust fund and not included in total Budget receipts. Receipts and payments under the proposed health insurance program would also be handled in this manner."

In other words the trust funds provided through payroll taxes for Social Security benefits are not included in the budget. However, a trust fund of $250 million through an employer-employee payroll tax to finance the preliminary administrative costs of a compulsory insurance plan is included. The health insurance payroll tax is one-quarter of one per cent on each employer and each employee. The budget does include $30 million to initiate the proposed Federal Aid to Medical Education plan and $25 million to initiate the proposed School Health Services plan.

The President estimated expenditures for the fiscal year 1951 (July 1, 1950, through June 30, 1951) at $42,438,756,406. During 1951 he estimated that the national debt would rise to $263,800,000,000. Last year he estimated expenditures for the fiscal year 1951 at $41,857,777,869. However, the Treasury statement of January 5th estimated that expenditures will run to $43,500,000,000. It is possible that if all contract and other authorizations are exercised that expenditures could run as high as 50.9 billion dollars according to a study reported by Congressional Quarterly in their publication of the week ending December 2, 1949.

Activities of the Editor

Recent speaking engagements of Dr. Jonathan Forman, Editor of *The Journal* include the following: Annual Meeting Friends of the Land in Pittsburgh; Flint (Ohio) P. T. A.; Licking County Medical Society; Exchange Club of Lancaster, and Lancaster Friends of the Land; Zanesville Rotary and Kiwanis Clubs, and Zanesville School Leaders; Miami County Medical Society; Oldsters Club of Bexley; Ohio Physical Educators; Ohio Valley Society of Allergists at Lexington, Ky.; Bexley Woman's Club; Mt. Sterling Rotary Club; Central Ohio Teacher's Association; National Catholic Rural Life Conference; Galion Child Conservation League; Shelby Mother's Clubs; Adena and Mt. Pleasant Garden Clubs; Central Ohio Academy of Pharmacy; Columbus Bar Association; and staff Benjamin Franklin Hospital.

Peril of Welfare State . . .

Noted Publisher Takes Issue With Statement of Historical Writer That Present 'Santa Claus' Theory of Government Is Here to Stay

NOT long ago Mr. John S. Knight, owner and editor of the *Chicago Daily News* and the *Akron Beacon Journal*, who is anything but a moss-backed reactionary, took his pen in hand and wrote a little piece in "The Editor's Notebook" which appears from time to time in his Chicago newspaper.

Inasmuch as Mr. Knight's comments are especially timely right now, with the Congress having under consideration a proposal, H. R. 6000, which would skyrocket the Social Security program, *The Journal* has taken the liberty of reprinting them, as reproduced by *Insurance Economics Surveys* which we assume presented an accurate copy of the original. Read what Mr. Knight has to say and then make up your mind as to what you had better do about making known your own views to your own Congressman:

* * *

The "welfare state," says historian Arthur Schlesinger, Jr., "is with us, for better or for worse." In fact, Mr. Schlesinger believes it started when Alexander Hamilton argued that the nation could not survive and prosper unless special government favors gave the business community a large stake in that survival and prosperity. According to Mr. Schlesinger, "the Hamiltonian handout theory remained substantially dominant in Washington" until a veto by Andrew Jackson forbade the use of national funds for a Kentucky highway.

Ironically, this is the same Andrew Jackson whose memory is honored throughout the nation every year by deserving Democrats who kick in $100 a plate to further the election of candidates who think President Jackson was the New Dealer of his day.

UNDERWRITING VS. HANDOUTS

Mr. Schlesinger takes a dim view of men like Herbert Hoover, who pronounced in his birthday address that "the welfare state . . . has emerged as a disguise for the totalitarian state by the . . . route of spending" . . . and that "our pursuit of the welfare state has already put us on the last mile to collectivism." He reminds the Hoovers and other critics of the welfare state that Alexander Hamilton's "handout theory" was developed and enlarged by the Republican party after the Civil War in the form of protective tariffs and land grants to private railroad companies.

"Why," says Mr. Schlesinger, "should Mr. Hoover and the other enemies of the welfare state find favors so reprehensible when bestowed by government upon farmers and workers, and so beneficial when bestowed upon business?" The historian then proceeds to answer his own question by the conclusion that the Hoover case against the dangers of the welfare state is based "on the most abominable hyprocrisy."

Protective tariff differs from handout: It seems to me that Mr. Schlesinger falls into loose reasoning when he attempts to make the protective tariff and government handouts appear as like peas in the same pod. Nor is there a true historical resemblance between land grants to railroads and a public dole. The early tariff laws were passed when infant American industries needed protection against foreign competition in order to survive.

In no sense did they constitute a government "handout" as we think of it today. Industrial development was essential to America's progress. It meant increased employment and the worker had just as great a stake in protection against "cheap foreign labor" as did the owners of the factory.

PROTECTION SERVED ITS PURPOSE

Our thinking is changed today because American industry has achieved a world dominance which the gradual breaking down of tariff walls cannot seriously threaten. The protection given from the post-Civil War era to the Smoot-Hawley tariff bill in 1930 is no longer needed. Most people now concede that the free flow of goods and services from one nation to another is essential to world economic stability. It was not so in the days to which Mr. Schlesinger refers.

Mr. Schlesinger falls into a similar error when he justifies welfare for all because at one stage in our history the government gave grants of land to private railroad companies.

Here again, America was in the early stages of her development and transcontinental transportation was vital to that development. While there was no dearth of risk capital for railroad expansion, no individual or corporate entity possessed the tremendous financial resources needed to acquire rights of way from one coast to another.

INVESTMENT IN TRANSPORTATION

The government wisely shared in this cost because of the sound belief that America would prosper in direct proportion to its spreading of

transportation facilities. Some backward nations, notably Russia, have never made this discovery.

It is ridiculous to argue that because the government gave a one-time subsidy to the railroads in their pioneering days, every group and class is now entitled to special benefits from Washington. One might as well contend that since the airlines do not construct and pay for every airport in the United States, their passengers should receive free flight insurance from the government.

* * *

Historian Schlesinger defines the welfare state as "a system wherein government agrees to underwrite certain levels of employment, income, education, medical aid, social security and housing for all its citizens." However, in another section of his recent article, he says: "Certainly, if, as the conservatives say, the welfare state is just a system of government handouts to any groups politically powerful enough to insist upon them, then even the most extreme liberal would be foolish to deny that such a system could harm.

SYSTEM RUNS AMUCK

"Handouts," he continues, "could easily create a dependence on the state that might sap the individual initiatives upon which free society depends, and, if the handouts were calculated, not according to economic plan, but according to political blackmail, they might well result in a grave weakening of the financial structure. The old-age pension schemes in California, Oregon, and Washington, for example, seem to be an example of a handout system running amuck."

Here, I submit, Mr. Schlesinger's definition of the welfare state and the possible abuse of a handout system reveals a distinction without a difference.

The extremes to which social welfare has progressed in the states of California, Oregon and Washington and the expense it entails appear mild by comparison with much of the legislation that has been introduced in the 81st Congress.

COMMITTEE CHECK VALVES

Fortunately, for the survival of a going economy and the ultimate welfare of the country as a whole, Congress has seen fit to dam up most of this political swill in committee.

One senator alone, the loquacious Hubert Humphrey of Minnesota, has introduced enough appropriation bills in this session of Congress to bankrupt the country within a few years.

Truman concepts rejected by Taft: Mr. Schlesinger, like most cultured liberals, evidently believes in the welfare state if it is not carried "too far." "The great issue," he declares, is whether the welfare state will become "a matter of bread and circuses." He even brings Senator Taft into his fold by concluding that while President Truman and the senator have bitter differences of opinion, "they are not over the welfare state."

He cites as evidence of Taft's conversion the senator's acceptance of government support for medical care, provided the care is dispensed as much as possible through the states and to be confined to the needy rather than to be available to all.

TENACIOUS LOCAL AUTONOMY

Here, Mr. Schlesinger does Senator Taft the same disservice as the hardshells who call Taft a Socialist because he favors public housing.

Taft is no more committed to Mr. Truman's concept of the welfare state than is U. S. Steel to the philosophies of Phil Murray. Moreover, it is Taft—not the liberals—who is striving to prevent the decay of individual initiative, which is the end result of guaranteed "security" for all.

The senator correctly recognizes there are certain areas in which the government has a continuing obligation to meet proper standards of education, medical care, and housing. This is quite different from the "bread and circuses" concept of social responsibility which Mr. Schlesinger fears and which Mr. Truman seemingly approves.

Groups will always compete for benefits: The trend toward socialism, either of the soft or the British variety, is a marked departure from traditional American philosophies. Socialism is a doctrine of futility; an acceptance of mediocrity; a shibboleth without substance.

Mr. Schlesinger believes that welfarism can succeed whenever the politicians of both the right and the left cease their demands for more pensions, more tariffs and more handouts . . . when each of the important special groups, meaning the business community, the farm bloc and the trade unions, recognizes that "it cannot blindly pursue its own narrow interest without threatening irreparable harm to society as a whole."

I am afraid that last statement strains my credulity too far, Mr. Schlesinger.

CONFLICT OF INTERESTS ALWAYS

You see, in individualistic America, there will always be a Senator Humphrey matching a Senator Bricker, an N. A. M. opposing a Walter Reuther, coal barons tangling with John L. Lewis, special interests for this and special interests for that.

The names may change but never will they lie down in the same pastures.

If, as you say, welfarism is here to stay, perhaps the Republicans and the Schlesinger liberals should adopt the slogan suggested by A. T. Burch, Associate Editor of the *Chicago Daily News.*

"You can't shoot Santa Claus but it's time to sober him up."

MR. TUCKER EXPOSES THE SUBTLE STRATEGY OF MEDICAL SOCIALIZERS

Will the Medical Profession—and the People—Be Lulled to Sleep and Outwitted?

READ the accompanying article from the January 7 issue of *The Ohio State Journal,* Columbus morning newspaper; then draw your own conclusions. If you think these measures add up to "the camel's nose under the tent," you should do something about it, namely: Let your Congressman know how you feel. The measures referred to are:

H. R. 5940 (also S. 1453) the so-called Aid to Medical Schools bill which has already been passed by the Senate, approved by the House Committee on Interstate and Foreign Commerce (Congressman Crosser, Cleveland, chairman), and in the hands of the House Rules Committee. The latter committee is being high-pressured to place the proposal on the calendar for a vote. Mr. Tucker refers to subsidies for nurse training schools. The bill, also would provide U. S. grants to medical schools.

S. 1411, the so-called National School Health Services bill, which has passed the Senate and is now awaiting hearings by the House Committee on Interstate and Foreign Commerce.

The Board of Trustees of the American Medical Association and The Council of the Ohio State Medical Association have adopted resolutions in opposition to both bills **in their present form.** The reasons for such action are substantially the same as the objections enumerated in Mr. Tucker's article.

Specific amendments to both of these bills have been offered to Congress by the Board of Trustees of the A. M. A. to correct undesirable features that the measures contain in their present form. Until proper corrective amendments are inserted in the bills, they will be opposed. If you write your Congressman, call his attention to the revisions suggested by the A. M. A.



Washington Whirligig

Seemly Innocuous Bills May Put Over Truman Health Plan

By RAY TUCKER

WASHINGTON.—Although White House legislative strategists seem to have abandoned hope of enacting a compulsory national health insurance measure during the current session, they aim to achieve a large part of their federalized medical program through passage of several seemingly innocuous but groundwork bills. Thereby they expect to lull and outwit the opposition.

In fact, a bill giving the government almost complete financial control of all schools for educating and training nurses, forerunner of schemes for federal domination of medical education, passed the Senate at the last session under peculiar circumstances, and was reported favorably by the House Interstate and Foreign Commerce Committee.

It would have been rushed through the lower chamber and become law save for a last-minute protest by Miss Dana Hudson of Atlanta, president of the Georgia Nurses' Association and superintendent of the Georgia Baptists' Hospital there.

When she accidentally discovered the far-reaching effect of the bill, known as the Emergency Professional Health Training Act, she mobilized a group of resentful nurses. They persuaded the House Rules Committee, which was about to place the measure on the legislative calendar, to set it aside for "further study."

The disputed bill provides for federal grants of money to nurses' training schools. Other measures in the same category propose similar governmental advances to institutions for education of physicians through establishment of federal scholarships. The underlying purpose is to relieve the reported shortage of doctors and nurses throughout the land.

* * *

THE NURSES' EDUCATIONAL measure is opposed by Miss Hudson's group on the ground that it gives politico-economic power over training schools to the government.

The Senate-passed bill provides that, for the purpose of qualifying for federal funds, nurses' training institutions shall be classified "in the order of their importance." They will get large or small sums, or none at all, on the basis of their "importance" in the general medical setup.

But all decisions as to each school's status will be made by a committee named by the President. And the group shall make its selections on the basis of advice from the Surgeon General, usually a personal or political appointee of the chief executive.

Another measure, which has also passed the Senate, stands in the same category, in the opinion of opponents of compulsory health insurance. They regard it as part of the plan to achieve the basis objective by the "bits and pieces" tactics — that is, passing measures quietly and separately.

The second proposal is known as the National School Services Act of 1949. It provides for prevention and treatment of "physical and mental defects and conditions of all children between the ages of 5 and 17, inclusive, attending school." That covers pupils from first grade through high school.

Distribution of the funds for administering this act would be in the hands of the Federal Security Administrator, not the states or local communities.

At the moment he happens to be Oscar R. Ewing, President Truman's efficient advance man in the 1948 campaign, ardent advocate of compulsory national health insurance and a lively candidate for the Democratic nomination for governor of New York next year.

* * *

THE LEGISLATIVE HISTORY of both bills is peculiarly interesting as revealing Administration strategy in the field of federalized medicine.

Both measures were called up in the Senate when only a few members were in their seats, and they were whooped through without a roll call. Their titles, which ring with idealistic promises, were read in a mumble-jumble monotone by the reading clerk, but their purpose was not explained in detail.

When they reached the House Interstate and Foreign Commerce Committee, Chairman Robert Crosser of Ohio was in Europe. Again with only a few members on hand, Acting Chairman J. Percy Priest of Tennessee rushed them out with a favorable report. Mr. Priest is top political aide to Democratic Majority Leader John W. McCormack of Boston.

In view of this background, it is doubtful if more than a handful of senators realize that they passed two of the medical measures most dear to Administration advocates of the so-called welfare state. Ironically, only a few members of the American Medical Association understood the significance of these bills.

(Ohio State Journal, Columbus, Ohio, Jan. 7, 1950.)

Licenses Granted . . .

State Medical Board Grants 26 Graduates of Medical Colleges Right To Practice in Ohio; List of Written Examination Questions Given

TWENTY-SIX graduates of Schools of Medicine were granted certificates to practice medicine and surgery in Ohio by the State Medical Board which met in Columbus January 16 and 17. The licenses were issued on the basis of examinations conducted by the Board December 12-14.

Highest grade in the examinations was made by Dr. William T. Breesman, Youngstown, Georgetown University School of Medicine, with an average of 88.7. Second highest grade was made by Dr. Enhew Sycz, Cincinnati, University of Cincinnati College of Medicine, with an average of 87.8.

In addition, 11 graduates of osteopathic schools were given certificates to practice osteopathic medicine and surgery and three applicants who appeared for additional examinations received certificates to practice osteopathic medicine and surgery.

In the limited branches, certificates were awarded to eight mechanotherapists; nine chiropractors; three chiropodists; eight cosmetic therapists, and 30 masseurs.

UNIVERSITY OF CINCINNATI COLLEGE OF MEDICINE:—Enhew Sycz, Cincinnati.

OHIO STATE UNIVERSITY COLLEGE OF MEDICINE:—James F. Alexander, Versailles.

GRADUATES OF OTHER SCHOOLS:—Chicago Medical School:—Elliot Migdal, Columbus.

Georgetown University School of Medicine:—William T. Breesman, Youngstown.

Hahnemann Medical College:—Glenn R. Black, Akron.

Marquette University School of Medicine:—Ben Storer, Holyrood, Kansas.

Northwestern University Medical School:—LeRoy K. Mills, Lyndhurst.

Syracuse University College of Medicine:—Eaton E. Freeman, Rochester, New York.

University of Illinois College of Medicine:—Richard W. Deatrick, Cleveland Heights; Mary M. Johnson, Benton, Illinois.

University of Pennsylvania School of Medicine:—Louis J. Jindra, Cleveland.

University of Pittsburgh School of Medicine:—Edward A. Carlin, Jr., William R. Cather, Harry R. Claypool, William H. Holloway, all of Toledo.

University of Rochester School of Medicine and Dentistry:—David L. Rodgers, Rochester, New York.

University of Utah School of Medicine:—Claude W. Dalley, Ypsilanti, Michigan.

Queens University Faculty of Medicine:—Murton R. Shaver, Cincinnati.

University of Manitoba Faculty of Medicine:—Norman C. Chivers, Cincinnati.

University of Toronto Faculty of Medicine:—Donald C. Wilson, Toledo.

Pazmany Peter University, Budapest:—Paul E. Foldes, Cincinnati.

Slovak University, Czechoslovakia:—Gustav Samak, Forest Hills, L. I., New York.

University of Dublin (Ireland) School of Physic:—Robert F. Holmes, Youngstown.

University of Kaunes, Lithuania:—Kasimeras Pautienis, Chicago, Illinois.

University of Prague Faculty of Medicine:—Valentine Mersol, Cleveland.

University of Iceland:—Frederic V. Kristoff, Cincinnati.

EXAMINATION QUESTIONS

Following are the written questions asked those who were examined to practice medicine and surgery:

ANATOMY

1. Describe the diaphragm in detail.
2. Describe the course and relations of the duodenum. Give its nerve and blood supply.
3. Give the origin, course and distribution of the left recurrent laryngeal nerve. What is the result of severing this nerve?
4. Name and locate the various cavities draining into the nasal canal.
5. Explain the anatomy of referred pain from the gall bladder, the diaphragm and the ureter.

PHYSIOLOGY

1. What is the estimated normal quantity of blood in the human body? How is the quantity kept constant? What is meant by the term "effective circulating volume"?
2. What are the hematopoietic functions of the spleen?
3. What is the function of the thymus gland?
4. What are the physiological effects of acromegaly?
5. Give the physiological properties of cardiac muscle that peculiarly fits it for the function it performs.
6. What is the function of the synapse?
7. What factors determine the composition of lymph? What factors govern the magnitude of pressures built up within the lymphatic system?
8. What is the emergency light reflex?
9. What are the physiologic mechanisms that govern the amount of water a human being ingests?
10. Discuss the part played by the skin in regulation of the body temperature during active muscular exercise.

BACTERIOLOGY

1. In order of relative frequency in which they are encountered, list four organisms that may be responsible for bacterial meningitis. Upon what characteristics would you rely for the identification of each of the four?
2. With what disease is trypanosoma gambiense associated? How is the disease transmitted?
3. Cite an instance in which two infective agents act in conjunction to produce disease, and another in which one interferes with the action of the other. How are these results brought about?
4. For each of the following tests, name a disease in which the test is of outstanding value in the diagnosis; (a) non-specific agglutination; (b) specific agglutination; (c) non-specific complement fixation; (d) specific complement fixation; (e) precipitation test.
5. Name two important members of the hemophilus group of micro-organisms and state the diseases caused by them.

CHEMISTRY

1. Define: (a) hemolysis, (b) defibrination, (c) plasma, (d) serum albumin.
2. What are the chief compounds included in the group

of steroids? What chemical structure is common to the group?
3. List the chemical factors that affect the secretion of gastric juice.
4. Discuss the nature of histamine; its occurrence and significance in normal metabolism and disease.
5. Give the norml range of CO_2 combining power of blood plasma.

DIAGNOSIS

1. Give signs and symptoms of hypothyroidism in a young lady eighteen years of age.
2. Name five anatomical defects of the human heart.
3. Are there any differential findings in nephrosclerosis and chronic glomerular nephritis.
4. Name five conditions that may produce blood in stools.
5. Give blood and physical findings in infectious mononucleosis.
6. Name some different conditions in which you find club fingers, spoon fingers and Heberden's nodes.
7. Give time, after first manifestation of acute rheumatic fever that you may expect heart change.
8. Give physical characteristics in anterior pituitary over-activity; also in posterior pituitary over-activity.
9. Give two symptoms found in tri-geminal neuralgia, migraine and histaminic cephalalgia that are peculiar to each condition.
10. Name four conditions that could cause chronic diarrhea.

MATERIA MEDICA AND THERAPEUTICS

1. Define and give example of: (a) acute poisoning; (b) cumulative poisoning.
2. In a patient with parathyroid deficiency, give the significant changes in the plasma level and urinary excretion of calcium and phosphate when parathyroid hormone is administered.
3. Give signs and symptoms of digitalis intoxication.
4. Give five (5) important conditions which modify drug action.
5. In carbon monoxide poisoning: (a) give manner of action of the carbon monoxide; (b) give treatment of poisoning from carbon monoxide.
6. By means of a tracing, show the effect of pitocin and pitressin upon blood pressure and uterine tonus.
7. (a) By what mechanisms may cardiac arrest take place during anesthesia? (b) Give treatment.
8. Is the RH factor important in choosing a donor whose blood will be used for a recipient who is RH negative and who has developed immune bodies to RH factor? Why?
9. Neostigmine (Prostigmine): (a) Therapeutic uses; (b) Dosage.
10. Outline the treatment of primary syphilis.

PATHOLOGY

1. In outline form, discuss the etiology and pathological anatomy of typhus fever.
2. Describe grossly the mitral valve in a case of chronic rheumatic cardiac disease in a patient about 40 years of age. Indicate the condition that is likely to be found in the lungs of the same patient.
3. In outline form, contrast the anatomical changes that may be found in the following diseases: (a) Malignant nephrosclerosis; (b) Chronic diffuse glomerulonephritis.
4. Write a concise definition of each of the following: (a) teratoma, (b) nasal polyp, (c) rhabdomyoma, (d) multiple myeloma, (e) hemangioma.
5. List the possible causes of hydrocephalus.
6. Name the three most common sites of formation of solitary abscesses of the brain and state the usual mechanism of infection involved in each.
7. Outline the pathogenesis of abscess of the lung. What are the more common complications?
8. In outline form, describe the microscopical appearance of a nodule in multiple myeloma. Name in the order of frequency the sites of occurrence of this tumor.
9. List the characteristics of the Pasteurella group of bacteria. Name two members of the group responsible for disease in man or animals.
10. How may the organism responsible for Asiatic cholera be identified. Outline the steps that should be taken to prevent the occurrence of an epidemic of this disease.

PRACTICE

1. Give the etiology and symptoms of small pox.
2. Give signs and symptoms of gout.
3. Give signs and symptoms of infestation with ascarides (round worms).
4. Give etiology and symptoms of tetanus.
5. Give the signs and symptoms of pulmonary tuberculosis.

SURGERY

1. Give the differential diagnosis between the following: (a) chronic cholecystitis; (b) recurrent appendicitis; (c) duodenal ulcer; (d) renal calculus.
2. Outline the treatment of a compressed fracture of the twelfth thoracic vertebra with partial paralysis of both lower extremities.
3. Describe an intertrochanteric fracture of the femur. Outline the management of this condition.

BETTER HURRY, IF INTERESTED IN SPECIAL TRAIN TRIP

AS indicated in the OSMAgram, dated January 13, plans are shaping up well for the Ohio State Medical Association Special Train to San Francisco in June when the American Medical Association will meet in that city. A three weeks' tour of the West, including five days in San Francisco during the convention, has been planned.

Reservations for the train are now being accepted at the Columbus Office. Many members who saw notices of this project in issues of the OSMAgram have written in for information on the itinerary, costs, etc.

Those who are interested in receiving this information should write the Columbus Office. It will be sent to them promptly. This should be done at once. Accommodations will be limited to approximately 150 persons. Part of this space already has been reserved by those who wrote in for information a month or so ago.

4. Give causes, symptoms, and physical signs of an abscess in the right temporal lobe of the brain.
5. Discuss briefly the etiology of gas gangrene. Describe the lesion and outline method of prevention and treatment.

OBSTETRICS AND GYNECOLOGY

1. What are the SIGNS which differentiate Abruptio Placenta from Placenta Praevia?
2. What are the conditions to be met for forceps delivery?
3. Outline proper pre-natal care.
4. Give symptoms, causes and treatment of tubal pregnancy.
5. Outline diagnosis and treatment of acute salpingitis.

SPECIALTIES

1. Name the three most common causes for a vesiculo, papular dermatitis associated with pruritus.
2. Name some conditions present in the body which will give a false positive complement fixation test. (Wassermann).
3. Draw a diagram labeling the important parts of the right ear drum.
4. True or false: (a) The pupil dilates on distant vision (true or false?); (b) The opening of the Antrum of Highmore is underneath the middle turbinate (true or false?); (c) Frequent colds means that the tonsils should be removed (true or false?) (d) An oily nose drop containing a weak ephedrine solution (½ per cent) is the ideal nose drop for babies (true or false?)
5. Outline and give treatment for a stone in the ureter.

PREVENTIVE MEDICINE AND HYGIENE

1. What procedures should be instituted relative to persons who have just been exposed to small-pox? Under what circumstances following the application of the necessary procedures can you declare such persons incapable of communicating small-pox to other persons?
2. Having established the diagnosis of diphtheria in a child what are your responsibilities as the physician to (a) the patient; (b) the family; and (c) the community?
3. Outline briefly the role of dusts in the production of diseases of the lungs. What general measures should be maintained for the prevention of these diseases?
4. Define: (a) potable water, (b) pasteurization, (c) epidemiology, (d) morbidity, (e) carrier-borne epidemic.
5. What are the essential points in public health inspection of places where food is prepared and served for public consumption?

'Doctors' Plan' Is Expanding . . .

Year's End Report Shows That Ohio Medical Indemnity Has 650,000 Persons Covered; Plans To Cover Non-Surgical Hospitalized Cases

DURING 1949, nearly 200,000 additional Ohioans secured Blue Shield protection through Ohio Medical Indemnity, Inc., the prepaid medical expense plan sponsored by the Ohio State Medical Association, bringing to 650,000 the number of persons covered.

At the end of the year, according to Mr. Charles H. Coghlan, Executive Vice-President of the company, more than 7,000 Ohio firms and businesses were cooperating on the payroll deduction plan. The company has 270,000 contracts in force, covering, as stated above, 650,000 persons.

The coverage of Ohio Medical Indemnity is now available in 82 of Ohio's 88 counties. Enrollment of subscribers and other administrative details are carried on by seven Blue Cross Plans in Ohio.

SMALL GROUPS COVERED

Mr. Coghlan pointed out that enrollment in 1949 was most encouraging throughout the state. He stated that while 3,000 additional groups were added, the company did not confine its activities to the enrollment of large industrial groups. Of the 7,000 groups now covered, over 80 per cent have less than 25 employees. The minimum number required for group enrollment in Ohio Medical is five. The "Doctors' Plan" is making it possible for the small business firms, merchants, gas stations and offices to secure adequate protection.

The Ohio Medical enrollment in the Blue Cross areas as of November 30, 1949, was as follows: Akron, six counties, 51,136; Canton, five counties, 61,487; Cincinnati, 14 counties, 255,598; Columbus, 29 counties, 133,547; Lima, eight counties, 13,800; Toledo, 12 counties, 86,973; and Youngstown, eight counties, 38,411.

Negotiations are now underway with Portsmouth Blue Cross for expansion to Scioto County in early 1950.

During 1949, $2,812,400 was paid in benefits to subscribers. This amount brings the total benefit payments, since the company started in January of 1946, to $5,405,500, representing 94,124 claims. Currently, over a quarter million dollars is paid monthly to subscribers.

During the year over-all administrative expense was reduced. Now less than 14 cents of every premium dollar is spent for operating the company, the balance of 86 cents being spent in benefits to subscribers and additions to reserves.

An important development during 1949 was the experiments conducted by Ohio Medical to make the plan available to non-group individuals. In conjunction with the Blue Cross plans, "community enrollments" were conducted in a number of areas in the state. In these campaigns, the individuals who were not eligible under the group plan were offered Blue Cross—Blue Shield for a limited time.

"We learned a great deal from these campaigns," Mr. Coghlan stated. "The interested county medical societies gave us whole hearted support and the doctors' recommendation was of great help in the enrollment," he said.

Experience figures on this type of enrollment are now being accumulated and studied and the company plans an extension of "community enrollments" in 1950.

Another step in providing Blue Shield coverage to more people occurred in the last quarter of 1949 when Blue Shield was offered to the non-group "billed-at-home" Blue Cross subscribers. This program was first offered through Blue Cross in the Cincinnati area and resulted in 38,000 members being enrolled. The program is now to be extended to other Blue Cross plans.

A special committee on medical care has nearly completed its work and in the next few months a "rider" contract will be offered by Ohio Medical. This contract will provide indemnities for medical illnesses (non-surgical) requiring hospitalization.

NATIONAL GROWTH

At a recent meeting of the Board of Directors, Dr. L. Howard Schriver, President of Ohio Medical Indemnity and President of the National Blue Shield Association, reported on the national growth of Blue Shield and Blue Cross plans. He pointed out that during 1949 the Blue Shield plans, nation-wide, had 3½ million members, bringing total enrollment in Blue Shield plans to approximately 14 million. Blue Cross plans, nation-wide, now cover in excess of 35 million Americans, three million of whom are enrolled through the Ohio Blue Cross plans. He further pointed out that the national association of Blue Shield plans was now in the process of organizing a national enrollment agency in order that firms with employees in two or more areas would be able to offer these employees uniform benefits. At the same time, the national enrollment agency will be beneficial to the national employer as it enables him to deal with one administrative Blue Shield office for all of his employees.

CONFERENCE FOR COUNTY OFFICERS AND COMMITTEEMEN AND MEETING FOR COUNTY AUXILIARY OFFICIALS

TWO important invitational working conferences in Columbus during March have been set up by The Council, namely:

Sunday, March 5, Annual Conference of County Society Presidents, Secretaries, Presidents-Elect, Chairmen of Legislative Committees and Chairmen of Public Relations Committees and Officers and Committeemen of the Ohio State Medical Association.

Tuesday, March 14, Conference of Presidents, Secretaries, Legislative Chairmen and Public Relations Chairmen of the County Woman's Auxiliaries under the sponsorship of the Ohio Medical Association.

Both Conferences will be held at the **Fort Hayes Hotel, 31 West Spring Street, Columbus, Ohio.**

Attendance will be by invitation. Invitations will be mailed four or five weeks in advance of the conferences. Those invited and planning to attend will be requested to sign a card so indicating, in order that luncheon reservations can be made. The luncheons will be complimentary.

The program for each conference will be built around reports on **current legislative problems and public relations activities.** A number of top-flight guest speakers have been invited. Programs will be mailed with the invitations.

It is hoped that those receiving invitations will make a special effort to attend—to find out what's going on and to discuss plans of action for 1950.

Causes of Accidental Death on Ohio Farms Analyzed

Nine farm people met with fatal accidents each week, on an average, for the past three years in Ohio. This is an annual accidental death rate of one person per 1,800 farm people. At this rate, in a lifetime of 60 years there is a chance of one in 30 that a farm person may die because of an accident.

The analysis of causes and frequency of deaths was made by R. B. Schwart and R. H. Baker and appeared in a bulletin of the O. S. U. Department of Rural Economics & Rural Sociology.

The 1,401 fatal accidents fall into three main types. The first group—about one-fourth of the total—occurred on the farm but outside of the home. More than one-half of these occurred during the four-month period from June to September. About 25 to 30 per cent involved farm machinery.

The second group—about 40 per cent of the total—occurred in the home. About two-thirds of the victims were over 65 years of age. Most of the deaths were caused by falls and fires.

The third group occurred off the farm. About 80 per cent were traffic accidents.

Dr. Robert M. Hall is the new secretary of the Council on National Emergency Medical Service of the A. M. A.

Name of "Hygeia" Changed To "Today's Health"

A change in name to *Today's Health*, effective with the March 1950 issue, was announced in the January *Hygeia*, health magazine of the American Medical Association.

The masthead of the January number also carried for the first time the name of Dr. W. W. Bauer, Chicago, as editor, succeeding Dr. Morris Fishbein. Dr. William Bolton, Chicago, is the new associate editor, succeeding Dr. Bauer. Ellwood Douglass will continue as managing editor.

Hygeia was established by the American Medical Association in 1923. Written for the layman, it has come to be one of the most widely quoted health education periodicals in the United States. There will be no change in fundamental policy under the new editorship or new name.

Alpha Chi Omega, national women's fraternity, has voted an additional grant of $10,000 to the National Society for Crippled Children and Adults, the Easter Seal agency, to continue a jointly sponsored scholarship program for training much-needed professional personnel to work with the cerebral palsied. This is in addition to a $15,000 previous grant.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

THINK OVER THIS ONE, DOCTOR

At a recent Ohio Conference on Citizenship in Columbus, Prof. Earl L. Shoup of Western Reserve University "rapped medical colleges for neglecting political science courses" and blamed the American Medical Association for failure "to urge its members to become conscious of civic and governmental affairs," according to a report on the meeting published in *The Columbus Citizen.*

If the reporter accurately reported the professor, Prof. Shoup is fifty per cent correct.

Most medical colleges have neglected to provide opportunities for their students to become exposed to civic, community and governmental affairs. Steps to correct that situation are being taken but there's plenty of room for more speed and improvement.

To blame the A. M. A. (or the Ohio State Medical Association) for failure on the part of doctors to take a more active interest in civic and governmental affairs is silly. Both of these organizations have been preaching this for years, as the records will show. Getting physicians to do something about it is a horse of another color.

It's high time for the individual physician to do something about it. The job can't be done out of Chicago or Columbus—or even out of the county seat. It's a job which has to be done by each individual physician out of his own office, in his own town, in his own neighborhood.

FUZZY THINKING ON PROBLEM IN ECONOMICS

Speaking at the National Social Welfare Assembly recently, Eveline Burns, member of the faculty of the New York School of Social Work, is reported to have said that "the question is not so much what America can afford, but how much social welfare does America want."

Sounds like a very simple answer to the question, doesn't it? In our opinion, the sentence should be stated in reverse. The question of what America—the taxpayers—can afford should come first. In making a budget, income has to be figured first. Whether or not a business or a governmental structure can afford what the budget calls for certainly has to be given equal standing with so-called "wants."

It's going to be difficult to get our economy on a sound basis and keep it there as long as this kind of fuzzy thinking goes on.

LET'S HAVE A REAL EPIDEMIC OF THIS

We like immensely the following paragraph, lifted from a recent News Letter of the Oklahoma State Medical Association:

"Physicians in Shelby County, Indiana, know actions speak much louder than words in developing good public relations. When a bad automobile accident there brought a night emergency call for doctors, seven rushed to the scene. The local newspaper commented: **'Shelby County doctors are providing their own best answer to the proponents of "free" medicine by providing the community with honest and skillful service—without a written order from the government.'** "

Here's hoping the "actions speak louder than words" epidemic spreads and that Ohio gets a good big dose of it.

QUESTIONS FOR MEDICAL SCHOOL SURVEY COMMITTEE

The two-year survey of medical education which is being made by the A. M. A. and the Association of American Medical Colleges will certainly be something more than just a routine inspection if a thorough forward-looking job is done.

Some of the questions which have to be studied —and answered—by the joint committee are pointed up in a recent editorial published by *The Modern Hospital.*

Some may not agree with all of the sentiments expressed in the editorial, but here it is, with no punches pulled:

"What is an intern? To the hospital patient, he is a young man who wears white pants and asks a lot of questions. To the practicing physician he is a useful assistant who makes examinations and takes histories in exchange for a few critical comments about diagnosis and other educational courtesies. To the hospital administrator he is a valuable commodity in short supply and getting shorter—probably because of a dark plot hatched by the medical schools and big teaching hospitals. To the intern himself he is something north of a clerkship and south of a residency, worried and hopeful by turns.

"Does the internship need redesigning in this day of residencies rampant, when most medical graduates are aiming at specialty practices that only a few will achieve? Is it sensible to continue approval of nearly 11,000 internships when there are only half that many interns? If that isn't sensible, what is? Should there be stricter limits on the number of internships approved for the big teaching centers, so that smaller hospitals can get a larger share of the available supply? Would that be fair to the interns?

To hospitals in both groups? To patients in both kinds of hospitals?

"These are just a few of the many questions about internships that the joint committee of the American Medical Association and the Association of American Medical Colleges must try to answer in the medical education survey which is now under way.

"Related to all these questions are the fundamental ones of how much medical service the nation needs and can pay for and how many facts can be stuffed into a student in a given period. According to Dean Hugh Long of Yale University, medical schools must now give thought to the situation in which 'nearly half the life of a man is passed before he can begin to be self-supporting in his profession.' Dr. Long proposes entrance to medical school at an earlier age and a combination of general education and preclinical training, a suggestion that will be viewed with dismay by other observers who see professional education already so lacking in general cultural content as to make doctors practically incommunicado with the rest of the world.

"With so many difficult problems to study, the medical education committee has a huge task on its hands. Nevertheless, the answers to two other questions that aren't often asked around medical schools or hospitals might be illuminating. These are: How many of the nation's physicians are discharging their sworn duty to 'impart a knowledge of the Art to . . . disciples'? How can those who aren't be given the opportunity and the inspiration to do so?"

SHADES OF HOUDINI— OR IS IT PONZI?

President Truman's new "prosperity timetable" for the next half century plunged amateur pencil experts into some bewildering statistics, the Washington Bureau of the *Cleveland Plain Dealer* reports to its home office. Read what the P. D. bureau has to say on some of the hocus-pokus emphasized in Mr. Truman's visionary message to the Congress in which he sets up a formula for about everything but how to wipe out a national deficit which is the greatest peace-time deficit in the history of the U. S. A.:

"The president told Congress that 'if our productive power continues to increase at the same rate as it has increased for the past 50 years,' production in the year 2000 would be nearly four times today's rate.

"That would be $1,000,000,000,000 (a trillion) annual national income as against today's $255,000,000,000 (255 billion).

"He predicted real income of the average family would increase almost three times—or $12,000 a year as against today's $4,200.

"Carrying the president's formula further:

"If Federal employees show a similar increase —today's 2,000,000 civilian employees represent an eight-fold expansion over the 250,000 civil servants of 1900—there will be 16,000,000 Federal employees by 2000.

"If taxes increase similarly—those of 1950 are 72 times as large as the Federal taxes of 1900—the nation's Federal tax load in 2000 A. D. will be $2,736,000,000,000.

"That's almost three times the annual income foreseen by President Truman for 2000.

"Assuming a population of 200,000,000 by the year 2000, that would mean a per capital Federal tax burden of $13,680.

"The average family of three persons would thus be paying Uncle Sam $41,040 annually in taxes while earning but $12,000 a year.

"How's that again, Mr. President?"

BIG DEVILS AND LITTLE DEVILS

Comments the *Saturday Evening Post*:

"In announcing himself as a candidate for governor of California, Jimmy Roosevelt explained that, while he was against 'socialized medicine, with regimentation of doctors and patients,' he was in favor of compulsory public-health insurance based on payroll deductions.

"In other words, Jimmy favors green apples, but is against bellyache."

To which we would like to add: Jimmy can stick his tongue in his cheek when he talks like others before him. He knows what socialized medicine is and isn't. Unfortunately, however, there are too many folks who don't. Too many think socialized medicine is some big he-devil waiting to pounce on an unsuspecting public. Could be; but how about the dozens of little he-devils in the form of seemingly harmless legislative proposals hiding around the corner ready to gang up for the kill? Those are the fellows who need watching.

MERCY SLAYING AND THE WELFARE STATE

John O'Donnell, Washington columnist for the *Ohio State Journal*, Columbus, offers a new slant to the so-called New Hampshire mercy-slaying involving Dr. Hermann Sander, which has received a big play in the press. O'Donnell contends that the case shall figure in the welfare state debate now raging in Washington. Read what he has to say, in part:

"* * * Dr. Sander, so far as he himself is concerned, rejected the principle by which doctors, ministers of the church and lawyers have been set aside from the general populace for centuries and by law and tradition are given special privileges denied to the average citizen. The physician gets his privileges by his faithful observance of the Oath of Hippocrates, that inspiring pledge and declaration of ethics and duty which has come down through the centuries.

" 'The regimen I adopt,' reads the historic oath, 'shall be for the benefit of my patients according to my ability and judgment and not for their hurt or for any wrong. I will give no deadly drug to any, though it be asked of me, nor will I counsel such and especially I will not aid a woman to procure abortion . . .

Whatsoever things I see or hear concerning the life of men in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets.'

"Now this oath of the old Greek naturally is ignored by the all-powerful state when it takes over the life and health of its citizens and makes doctors its civil servants, medical schools its tax-kept hand-maidens, faculties the stooges of bureaucrats and hospitals the private domain of government bureau chiefs.

"Dr. Sander seems to have done it on his own—and perhaps pointed to the road ahead for the welfare state.

"This has happened in Russia and Hitler got pretty far down the road of socialized medicine; mercy killings were legalized, the euthanasia (happy death) of the hopelessly insane became standard procedure except in communities where the Catholic Church was strong enough to block the decrees. This line of thought led naturally enough in the final years of the war to the scientific and thoroughly aseptic mass murder of millions of Jews. That, of course, was inevitable; once the individual human being sets up shop and declares his right to determine the life and death of one human being, the logical conclusion is inevitable: mass murder."

O'Donnell has a point. Some may think his reasoning far-fetched. Yet, the dictators abroad weren't such bad chaps when they started out, were they?

LONG JAUNT BUT WORTH IT

Probably one of the shortest editorials on record against socialized medicine is the following, published in the January 8, 1950, issue of the *Cleveland Plain Dealer*:

"Count Christian Lerchenborg of Copenhagen, Denmark, came to Johnstown, Pa., when he wanted to undergo a sinus operation.

" 'Medicine,' said the count at the end of his 3,000-mile trip, 'is socialized in Denmark.'

"Hmmmmmmmm!"

AID OF HEALTH DEPARTMENT OFFERED DOCTORS

Dr. John D. Porterfield, director of the Ohio Department of Health, has offered the services of that Department to physicians of the State in an effort to trace down the probable cause of "blue baby" illness. In an article in the December issue of *The Journal*, Dr. Porterfield stated that the personnel of the Department would analyze the local water supply of any family in which a physician reported a case of infant "blue baby" illness.

This is another excellent example of how the State Department and physicians can cooperate for the advancement of medicine. Here the work of the health agency in preventive medicine and the work in curative medicine of the private practitioner meet on common ground.

RED CROSS TO STAGE ANNUAL CAMPAIGN

Every March the American Red Cross goes to the people for support of its program. This program entails responsibilities of national and international scope that continue both in war and in peace.

The Red Cross puts the campaign on a voluntary basis—both as to those who take part in the canvass and those who contribute. However, balanced against this "voluntary" provision is a responsibility which removes the opportunity far from the take-it-or-leave-it class.

The term "Red Cross" has become synonymous with emergency relief. It is the agency the average citizen looks to in case of disaster to a family or to a state.

The American Red Cross has 38,000,000 members in 3,746 chapters. It reports that there is a Red Cross organization in every county in the United States.

Here is another opportunity about which doctors should deliberate carefully before they pass it up. The Red Cross is closely associated with community health and welfare. When the helping hand of the Red Cross is extended, contributors of time or money can take a great deal of pride in knowing that they contributed toward extending that hand.

PAMPHLET STRESSES CARE OF DOGS IN RESEARCH

The Surgery Study Section of the National Institutes of Health has published a pamphlet, "Care of the Dog Used in Medical Research."

Undoubtedly this pamphlet will add materially to the scientific information of those who are engaged in research involving animals, but perhaps an even more important point is that it will help fill a need in an annoying public relations problem.

The whole field of research involving the use of animals is under unwarranted and fanatical attack. Unfortunately many research scientists have been called upon to defend themselves against unwarranted charges of abuse of animals.

Scientific care of animals before and during research will do much to make a favorable impression on legislators and others who are genuinely interested in the matter from a humane as well as from a research point of view.

HALF-HEARD—OR PERHAPS VERY POORLY TOLD

A favorite pastime of many is that of taking digs at the newspapers for allegedly getting the facts mixed in reporting a speech or incident. Did you ever stop to think—if trained reporters get the facts confused, how much more confused must the casual observer or listener get them? A good precept to follow is—Thoughts for men in terms that children can understand.



The Bettman Archive

The nausea, vomiting and dizziness of motion sickness may be prevented or relieved, in a high percentage of cases, with Dramamine* (brand of dimenhydrinate).

DRAMAMINE for the Prevention and Treatment of Motion Sickness.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Trademark of G. D. Searle & Co., Chicago 80, Illinois

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Do You Know? . . .

According to the *New York Times*, one out of every four persons, aged 65 or over, in the United States is on public assistance rolls.

* * *

The articles by Hon. Harold E. Stassen on the British health program, which appeared in the January and February issues of *The Reader's Digest*, are being reprinted for national distribution. Whitaker & Baxter, directors of the National Education Campaign, American Medical Association, will mail 15 copies of each article to every physician in the United States for use in his reception room.

* * *

Dr. Jonathan Forman, Columbus, has been selected to serve his fourth term on the Board of Directors of the Ohio Chamber of Commerce and his second term as Chairman of the Board of Trustees of the Franklin County Historical Society.

* * *

Twenty health and hygiene officials from Columbus and Dayton have organized the Ohio Family Foundation as a state-wide group to fight venereal disease. Officers are: Dr. H. H. Williams, Dayton, city health commissioner, president; Dr. Charles Freeble, Columbus, chief of the communicable disease division, Ohio Department of Health, vice-president; Earl Wright, Columbus, secretary; Miss Florence Fogle, Columbus, treasurer.

* * *

"Keep Your Health," the health education radio program sponsored by the Ohio State University College of Medicine under the direction of Dr. Jonathan Forman, was resumed over WOSU, Tuesday evening, January 17, at 6:30 p. m. It will continue for 42 weeks.

* * *

The National Blood Program of the American Red Cross is now supplying blood to 1,550 hospitals in 35 states. More than 500,000 pints of blood were provided last year through 30 regional blood centers.

* * *

The National Foundation for Infantile Paralysis has granted $25,480 to Western Reserve University School of Medicine for the continuation of a research project begun in 1947 to find some chemical means to protect nerve cells from polio virus.

* * *

Dr. Paul R. Hawley resigned as chief executive officer of the Blue Cross and Blue Shield Commissions to become director of the American College of Surgeons, effective March 1. He succeeds Dr. Malcolm T. Mac Eachern.

"They Also Serve," a 16 mm black and white sound motion picture depicting the physician's role in disasters is now available for presentation at medical society or hospital staff meetings. It was prepared by the American Medical Association in collaboration with technical advisors representing the United States Army, American Red Cross and the U. S. Public Health Service. The showing time is 17 minutes. The film is procurable on loan (service charge $2) or purchase from the Committee on Medical Motion Pictures, A. M. A., 535 N. Dearborn St., Chicago 10.

* * *

The American Association of Blood Banks has named Dr. Paul I. Hoxworth, Cincinnati, president-elect.

* * *

General Motors Corporation has appropriated $1,215,000 for contributions to the building campaigns of hospitals in Dayton.

* * *

Dr. William C. Woodward, first director of the Bureau of Legal Medicine of the American Medical Association and Legislation, died at his home in Washington, D. C., Dec. 22, aged 82. He was director of the Bureau from 1922 until his retirement on Jan. 1, 1940.

* * *

New officers of the Ohio State Veterinary Medical Association include: Dr. H. K. Bailey, Wilmington, president; Dr. S. W. Stout, Hamilton, president-elect, and Dr. W. H. Pavey, Xenia, member of the executive committee.

* * *

According to a recent press dispatch from Washington, only one-third of the patients in veterans' hospitals are there for treatment of illnesses which resulted from their military service. The figures showed 36,432 beds occupied by service-connected cases and 71,165 by non-service connected cases. The report for the veterans' hospitals in Ohio showed 1,450 service-connected cases and 2,912 non-service connected cases.

* * *

One hundred and ninety senior medical students have been appointed to Army internships beginning next July 1, Major General R. W. Bliss, the Army Surgeon General, has announced. They represent the Army's selections out of the 1014 candidates who applied for both Army and Air Force internships.

* * *

The total number of American women who are employed or seeking employment has fallen off since the end of World War II but still exceeds the 1940 figure by some 4.8 millions. The estimated total is 18.6 millions, or about 30 per cent of the country's entire labor force, according to Metropolitan Life.



Even a flood...

failed to stop GE Service!

It was spring in Marietta and the Ohio River was on its seasonal rampage. In fact, its swollen waters were even licking at doorsteps in the busy downtown section — eagerly reaching higher and higher.

Is it any wonder, then, that one of the town's leading x-ray technicians should be alarmed for the safety of her charge — vital, valuable x-ray equipment in the flood-threatened office of her employer, a well-known Marietta doctor. Quite naturally she telephoned GE's Columbus, Ohio office — told of her plight.

GE Service went into immediate aciton. Checked State Highway Department — found roads to Marietta water-blocked. Then, chartered a plane which landed across the river from Marietta at Williamsburg, W. Va., about an hour later. After reaching downtown Marietta by flatboat and walking a few blocks, the GE serviceman arrived across the street from the doctor's office. However, flood waters blocked the way. This problem was neatly solved when a stalwart dentist friend happened along and volunteered to carry him and his equipment across the street piggy back.

The x-ray equipment was speedily dismantled, loaded on a high wheeled truck and taken to the doctor's home which was located on higher ground.

This story is typical of the hundreds of documented GE Service reports in our files. A service which proudly lends a new, broader conception to the guarantee that stands back of every GE installation.

Don't wait for a flood to call for GE Service... its available always at —

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GENERAL ELECTRIC X-RAY CORPORATION

On the Firing Line . . .

Shots at Truman-Ewing Compulsory Sickness Insurance Scheme; Ammunition For Doctors in Speeches Against Federalized Medicine

"What the American must understand, however, is that while each of these proposals—Federal invasion of banking, Federal invasion of power, and socialized medicine—is promoted as if it were just a single reform unrelated to all others, the simple fact is that each is intended to liquidate some sector of the private enterprise system and expand the area of socialism." —*John T. Flynn, The Road Ahead.*

* * *

"The greatest fear in Britain today is not the fear of war, nor of Russia's Atomic bombs. It is the fear hounding Britain's middle class—traditional backbone of the nation—that it is being possessively wiped out by skyrocketing living costs and taxes under Britain's Socialist regime."—*Seymour Berkson, General Manager, International News Service.*

* * *

"In the days ahead of us, there will be a struggle between those who believe in individual freedom and those who would subordinate the individual to the dictates of the government. There will be a struggle, too, between those who would transfer even greater powers to the Federal government, and those who would stand by the Constitution in its reservation of powers to the States."—*James F. Byrnes, former Secretary of State, in Readers Digest, September, 1949.*

* * *

"The National Health Service is about 11 per cent of the national budget, or approximately £3,250,000,000."—*The National Health Service of Great Britain, by Williard C. Rappleye, M. D., Dean and Professor of Medical Economics, Faculty of Medicine, and Vice-President in Charge of Medical Affairs, Columbia University.*

* * *

"Can it be that the country, that Americans have come to accept the idea that a free economy cannot walk without a perpetual government crutch?"—*Arthur Capper.*

* * *

"For the state to usurp the responsibility for medical care of its citizens . . . constitutes an infringement of human responsibility and individual freedom which God has not given to the state . . . The state has no right to require by law, force or other method the submission of the body to its paternal care . . . The battle (against compulsory health insurance) is not for the doctor alone but it belongs to all Christian people who cherish their own freedom . . ."—*American Council of Christian Churches.*

* * *

"This is no time for us to throw out our system of government and follow England." —*Sen. Robert A. Taft.*

* * *

"What has happened in England could happen here. Secretary of Agriculture Brannan himself told me he wasn't interested in politics. He is a sincere man. Yet I saw his plan introduced at a Democratic National Committee session last June in Des Moines. I then knew the proposal would take its place with socialized medicine, a vastly expanded social security program, and other Fair Deal movements."—*Bill Zipf, Columbus Dispatch farm columnist.*

* * *

"Not only the practice of medicine, but our entire economy is being pushed into a Socialistic state under the guise of 'welfare.' The welfare state may well be the farewell to our American way of life."—*Dr. Herman Kretschmer, Chicago, former president of the A. M. A.*

* * *

"Beware of the Greeks bearing gifts. Beware of those who promise you something which does not belong to them and which can be given to you only at your own expense."—*James F. Byrnes, former Secretary of State, in the Readers Digest, September, 1949.*

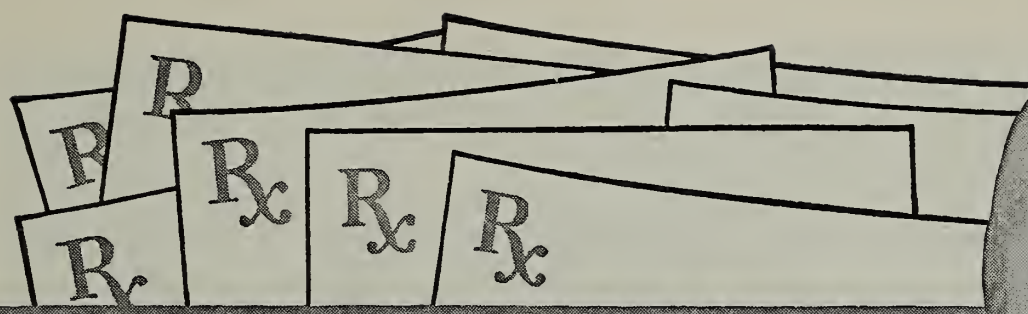
* * *

"The Fair Deal must be judged by its deeds. These deeds have been a persistent, enlarging assaut on free-enterprise in the United States aimed at the creation of a welfare-state socialism."—*The Columbus Dispatch.*

* * *

" 'The Welfare State' is a government device for the socialization of man. It is a movement in the direction of Socialism, that is, government ownership of the means of production, distribution and exchange, because if man is socialized, whatever he possesses must, in due course, be socialized."—*George E. Sokolsky.*

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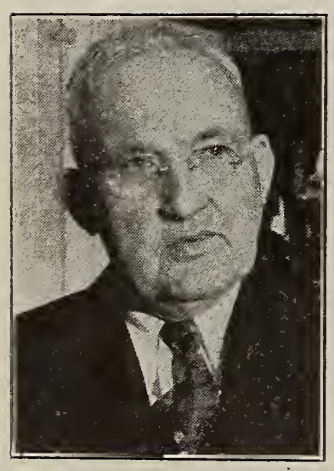
ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

In Memoriam . . .

William Jamieson Abbott, M. D., Cleveland; University of Toronto Faculty of Medicine, 1905; aged 75; died Nov. 15; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1947; diplomate of the American Board of Otolaryngology; member of the American Laryngological, Rhinological and Otolaryngological Society; past-president of the Cleveland Ophthalmology Society. Dr. Abbott began his practice in Cleveland in 1905 and continued until his retirement about two years ago. Surviving are his widow, a daughter and two sons, one of whom is Dr. William E. Abbott of Detroit.

Clinton John Altmaier, M. D., Marion; Ohio Medical University, Columbus, 1905; aged 67; died Jan. 10; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Altmaier began his practice in Marion in 1915 when he went there as surgeon for the Marion Steam Shovel Co. In addition to his practice, he was active in civic and political affairs. He was a member of the Ohio State Democratic Committee and served as central committeeman of the Eighth Congressional District and as chairman of the Marion County Democratic Committee. He served a time as medical examiner for the Ohio State Industrial Commission. He held memberships in the American Legion, the Masonic Lodge, the Elks, Odd Fellows, Knights of Pythias, Eagles and Moose. Surviving are his widow, one son, Dr. Clovis Altmaier, also of Marion, and a brother.

Samuel Vincent Burley, M. D., Lorain; Medical College of Ohio, Cincinnati, 1897; aged 74; died Dec. 23; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Upon creation of the Eleventh District in 1939, Dr. Burley was elected to represent that district on the Council of the Ohio State Medical Association and served as Councilor until 1942. He was vice-president of the Lorain County Medical Society in 1919 and its president in 1928; served as Legislative Committee chairman, 1922, 1931-36 and 1938; and delegate to the O. S. M. A., 1926-27, 1930-39 and 1946. Dr. Burley had practiced medicine for more than 52 years, most of which time was served in Lorain. Recently he was presented the 50-Year Pin and Certificate of the State Association. He served for 15 years on the Lorain School Board, 13 years as its president. He was a member of the Masonic Lodge. Surviving are his widow, a son, a daughter and three brothers.



S. V. BURLEY, M. D.

Oscar S. Brown, M. D., Oceanside, Calif.; Starling Medical College, Columbus, 1886; aged 91; died Dec. 6. Dr. Brown practiced only for a short time in Ohio before going to California. Surviving are his widow, a daughter and two sons.

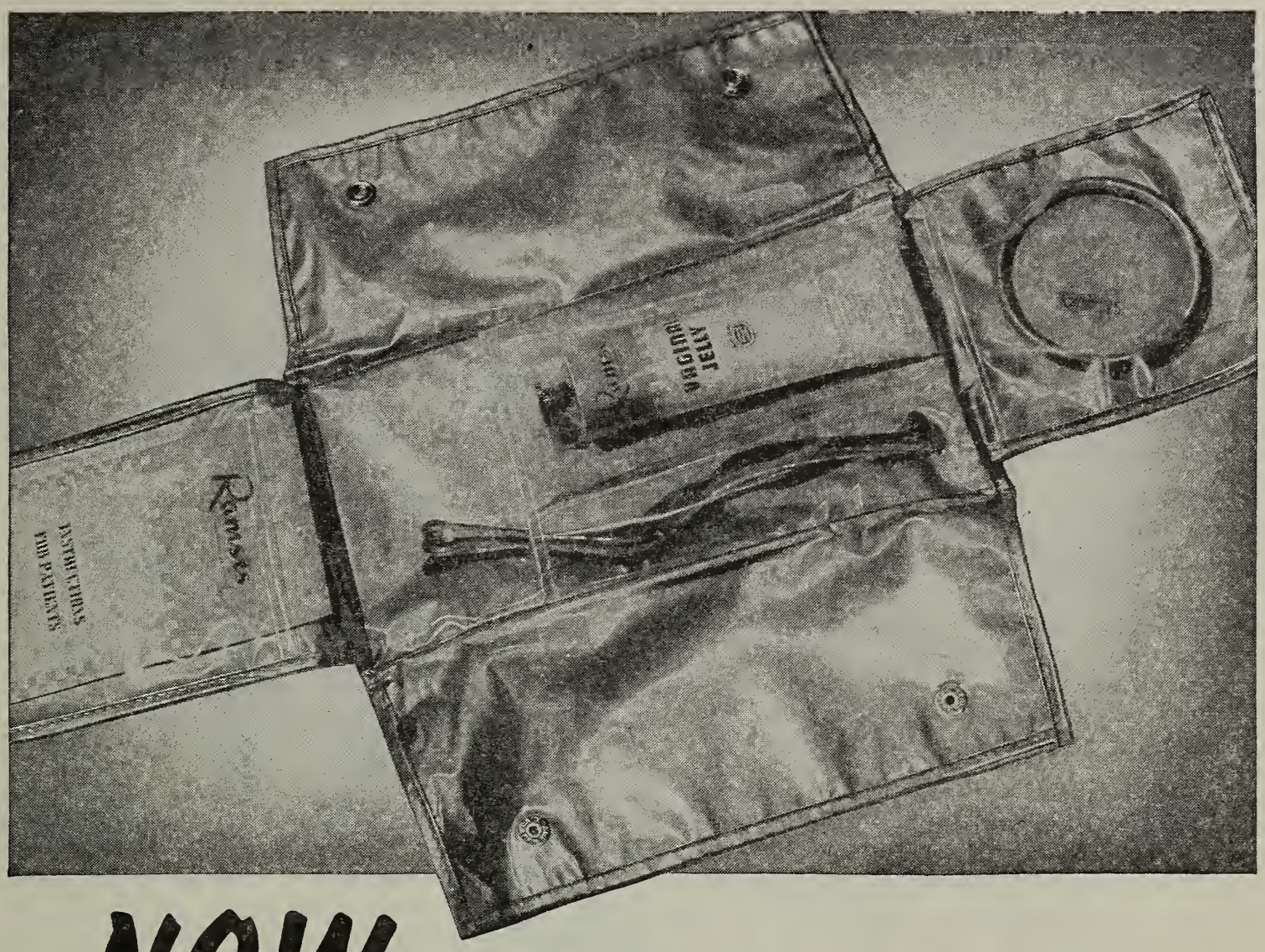
James Jefferson Carter, M. D., Columbus; Meharry Medical College, Nashville, Tenn., 1921; aged 61; died Jan. 3 as the result of a traffic accident; member of the Ohio State Medical Association and the American Medical Association. Dr. Carter moved his practice to Columbus from Kansas City in 1935. Organizations with which he was affiliated included the Elks Lodge, Alpha Phi Alpha fraternity, Stewards' Board No. 1 of the A. M. E. Church, O. B. G. Men's Charity Club, Masonic Lodge, American Woodmen's Lodge, and the Columbus Chamber of Commerce. He was one of the founders of the Frontiers Clubs of America, and was on the board of directors of the Urban League of Columbus. He was past-president of the Buckeye State Medical, Dental and Pharmaceutical Association and of the Franklin County Medical, Dental and Pharmaceutical Association, and was secretary of the National Medical Association. Surviving are his widow, a daughter, his mother and four brothers.

Robert Stanley Coppess, M. D., Springfield; Ohio State University College of Homeopathic Medicine, 1919; aged 59; died Jan. 6; former member of the Ohio State Medical Association and the American Medical Association through 1946.

Charles Larmon Dolle, M. D., Westerville; Columbus Medical College, 1892; aged 83; died Jan. 8. Dr. Dolle had practiced in the vicinity of Westerville most of his life. He was founder and owner of the Westerville Sanitarium. Surviving are his widow, four sons, a daughter, two brothers and three sisters.

Edwin Fauver, M. D., formerly of Oberlin; Columbia University College of Physicians and Surgeons, 1909; aged 74; died Dec. 17 while in Florida. Dr. Fauver for a number of years had been director of the department of physical education and health at the University of Rochester, N. Y., and had been active in organized college athletic activities in New York State. Surviving are his widow, one son and a sister.

Bert Edward Goodman, M. D., Warren; Jefferson Medical College of Philadelphia, 1903;



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gynecological division

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aged 73; died Dec. 19; member of the Ohio State Medical Association and the American Medical Association through 1948; vice-president of the Trumbull County Medical Society in 1922 and its president in 1923; delegate to the O. S. M. A. in 1923. Dr. Goodman had practiced in Warren and vicinity from 1914 until his retirement about a year ago. He served as local school physician for 12 years, was a charter member of Alpha Omega Alpha fraternity; was a member of the Methodist Church and several Masonic orders. Surviving are his widow, three sons, one of whom is Dr. William E. Goodman, also of Warren, and two sisters.

Leslie Mac Lisle, Sr., M. D., Columbus; Starling Medical College, Columbus, 1902; aged 72; died Dec. 12; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Lisle had practiced in Columbus for approximately 45 years until his retirement two years ago. Surviving are his widow, a son, Dr. Leslie M. Lisle, Jr., also of Columbus, a daughter and a sister.

William Hacker McKibben, M. D., Los Angeles, Calif.; Medical College of Ohio, Cincinnati, 1891; aged 80; died Jan. 4; former member of the Ohio State Medical Association and the American Medical Association through 1933. Dr. McKibben had practiced in Cincinnati and Moscow before moving to Reynoldsburg where he practiced until his retirement a number of years ago. Surviving are his widow and a brother, Dr. James T. McKibben of Cincinnati.

John Orpheus Newton, M. D., Cleveland; Vanderbilt University School of Medicine, Nashville, 1930; aged 44; died Dec. 16; member of the Ohio State Medical Association and a Fellow of the American Medical Association; diplomate of the American Board of Radiology; member of the Radiological Society of North America, Inc., and the American College of Radiology; past-president of the Cleveland Radiological Society. Dr. Newton had been chief of the Radiological Department at Huron Road Hospital. He was a member of the State Power Squadron since before World War II, was a member of Alpha Tau Omega and Alpha Kappa Kappa and the Methodist Church. Surviving are his widow, two sons and his mother.

Joseph Price, M. D., Columbus; Starling Medical College, Columbus, 1904; aged 73; died Jan. 8; member of the Ohio State Medical Association and a Fellow of the American Medical Association; member of the American College of Surgeons; president of the Columbus Academy of Medicine in 1931. Dr. Price served his entire medical career in Columbus where he founded and headed the Mercy Hospital. During World War I he served as a major in the Army Medical Corps. He was affiliated with several Masonic orders, the Kiwanis Club and the Columbus Athletic Club. Surviving are his widow, and two sisters.

James Corey Riffe, M. D., Covington, Ky.; University of Cincinnati College of Medicine, 1930; aged 46; died Dec. 23; member of the Kentucky State Medical Association and a Fellow of the American Medical Association. His widow survives.

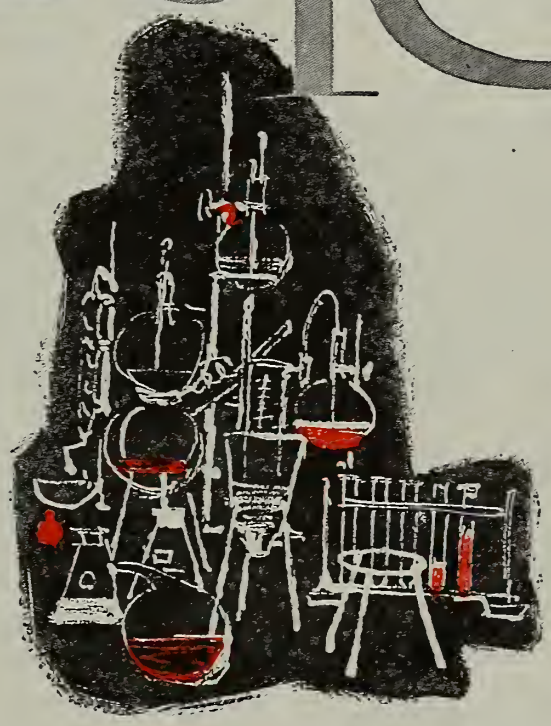
Scott Clark Runnels, M. D., Claremont, Calif.; Indiana Medical College, School of Medicine of Purdue University, 1907, and University of Michigan Homeopathic Medical School, 1908; aged 67; died Jan. 2; former member of the Ohio State Medical Association through 1946 and a Fellow of the American Medical Association; diplomate of the American Board of Obstetrics and Gynecology. For 17 years Dr. Runnels had been head of the Department of Pediatrics and Gynecology at Huron Road Hospital. From 1941 until 1945 he had been with the Army Medical Corps where he held the rank of Colonel. Surviving are his widow and a daughter.

John Augustus Toomey, M. D., Cleveland; Western Reserve University School of Medicine, 1919; aged 60; died Jan. 1; member of the Ohio State Medical Association and a Fellow of the American Medical Association; diplomate of the American Board of Pediatrics; member of the American Pediatrics Society, the American Academy of Pediatrics, the American College of Physicians and the Society of American Bacteriologists. In charge of City Hospital's Contagious Diseases and Pediatrics Divisions and professor of clinical pediatrics and contagious diseases at Western Reserve University School of Medicine, Dr. Toomey's death brought to a close 37 years at City Hospital and 29 on the medical faculty. While a graduate student he was in charge of the hospital storeroom and some time after his graduation from medical school he returned to the hospital in a professional capacity, becoming head of the Contagious Diseases Division in 1922. Dr. Toomey, recognized as an authority on the treatment of poliomyelitis, pioneered in a method said to be one of the most effective to aid in the recovery of polio patients. His contributions to medical literature give testimony of his great interest in clinical investigation and laboratory research. During his medical career more than 350 of his scientific papers were published. In 1948 he served as president of the American Academy of Pediatrics. In 1949 he received the honorary degree of Doctor of Laws from John Carroll University. He was president of the Western Reserve Medical Alumni Association for the year 1947-48. Colleagues last September presented Dr. Toomey with a portrait by Rolf Stoll. He was a member of the Catholic Church.

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Aureomycin has been shown to be highly useful in the control of staphylococcal infections, many of which exhibit a high degree of resistance to other antibiotics and chemotherapeutic agents. The prognosis in systemic staphylococcal infections is sufficiently serious so that the optimum treatment should be administered immediately, and continued for one or several days after the temperature has subsided to normal.

Aureomycin has been found effective for the control of the following infections: bacteroides septicemia, brucellosis, Gram-negative infections — including those caused by the coli-aerogenes group, Gram-positive infections — including those caused by streptococci and pneumococci, granuloma inguinale, lymphogranuloma venereum, *Hemophilus influenzae* infections, primary atypical pneumonia, psittacosis, Q fever, rickettsialpox, Rocky Mountain spotted fever, penicillin-resistant subacute bacterial endocarditis, sinusitis caused by susceptible organisms, tularemia, typhus, bacterial and viral-like infections of the eye.

Capsules: Bottles of 25, 50 mg. each capsule. Bottles of 16, 250 mg. each capsule.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

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Dr. Toomey's first wife, the former Miss Mary L. Bagot, died in 1947. His second wife, the former Miss Helen K. Toomey, survives. Also surviving are four children, including Dr. Charles H. Toomey of New York City and Miss Frances Toomey, a student at Marquette University School of Medicine; also three brothers and three sisters.

Raoul Lazaar Vioran, M. D., Akron; Jenner Medical College, Chicago, 1910; aged 66; died Dec. 7; member of the Ohio State Medical Association and the American Medical Association. Dr. Vioran had practiced in Akron for approximately 32 years and since 1942 was surgeon for the local police and fire departments.

Joseph Gilbert Whitacre, M. D., Lodi; Ohio State University College of Homeopathic Medicine, 1917; aged 62; died Jan. 7; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Whitacre had practiced in Medina County and the surrounding areas for approximately 33 years continuously except for the time he and his wife spent studying abroad. He held memberships in a number of professional organizations. Surviving are his widow, Dr. Clarice E. Whitacre, and two daughters.

Barnett Edgar Winters, M. D., Columbus; Starling Medical College, Columbus, 1896; aged 82; died Jan. 6; member of the Ohio State Medical Association and the American Medical Association. Dr. Winters had been in practice for approximately 53 years. He moved to Columbus from New Straitsville, Perry County, about 31 years ago. He was a member of the Methodist Church. Surviving are his widow, a daughter, a brother and two sisters.

Workers' Welfare To Be Subject Of Industrial Health Congress

The health and welfare of workers in industry and business will be the subject of the 10th annual Congress on Industrial Health at the Hotel Roosevelt, New York, February 20-21. The meeting, sponsored jointly by the Council on Industrial Health of the American Medical Association and the Medical Society of the State of New York, will be participated in by the medical profession, labor, management and others interested in health care programs.

Most of the discussions during the congress will be directed toward clarifying the objectives of industrial health services and bringing these benefits to more workers.

One phase of the congress will be a symposium on voluntary health insurance plans. The discussion will cover union, management, private insurance, medical society and Blue Cross plans for industrial workers. This will be conducted by the A. M. A. Council on Medical Service.

Low Level of Soviet Medicine Laid To Shackling of Doctors

The low level of medical care in the Soviet Union results from restraints on doctors, says an editorial in the December 24 *Journal of the American Medical Association.*

"Unfortunately for Soviet citizens, Soviet medicine does not appear to be as good as Soviet propaganda," the editorial points out.

"In fact, few factual data may be found published concerning the quality of Soviet medicine. Most evaluations outside the U. S. S. R. are based on observations of foreigners who have been in the country and on the reports of Soviet refugees.

"However, on rare occasions frank articles have appeared in Soviet periodicals. When the boasting is discounted and the facts critically examined these articles reveal a disturbing state of affairs.

"Official statements said to be attributed to a Minister of Public Health revealed shortages of equipment in every medical field. Drugs were claimed to be often of poor quality, and their faulty distribution is said to have caused serious shortages. Medical clinics and institutions have increased in recent years, but rural areas, it is said, still are lacking even minimum medical care and large areas are practically without facilities for surgery.

"Physicians and nurses are reported to be poorly trained and to have few opportunities to specialize. Even the former Minister of Health admitted in some instances 50 to 75 per cent error in diagnosis, which, if true, is a sad reflection of the care available to the Soviet citizen.

"Apparently opportunities for advanced training and for personal advancement are hampered also by a shortage and the inadequate quality of medical publications and a limited circulation of those that are published. The ministry probably publishes fewer than thirty journals and only one, *Soviet Medicine*, is suited to the majority of practitioners. However, even the Minister of Health once admitted that few articles in *Soviet Medicine* were of interest to doctors."

The Clinical center being built for the National Institutes of Health, chief research branch of the Public Health Service, is at Bethesda, Md. A combined hospital and research institution, it will house one of the best-equipped medical and basic science laboratories, together with hospital facilities for 500 patients. The $40,000,000, 14-story, air-conditioned building is scheduled to be completed by July, 1952.



Good Nutrition..

A VITAL FACTOR IN THERAPY

The sound and wholesome nutritious diet is an integral part of modern day preventive and definitive therapy. A steady stream of adequate amounts of all the essential nutritional elements is vital for good growth, maintenance of tissue structure and functioning, healing after trauma, and resistance to infection. For maintaining this daily, steady stream of nutrients, however, conditions both in health and illness often make imperative the use of an efficient food supplement along with the diet.

The *multiple dietary food supplement* Ovaltine in milk has wide usefulness for enhancing to full adequacy even nutritionally poor diets. Its rich store of vitamins and minerals includes vitamins A and D, ascorbic acid, thiamine, riboflavin and niacin, and calcium, iron and phosphorus. Its nutritionally complete protein has excellent biologic rating.

Since these vital nutritional values along with carbohydrate and easily emulsifiable milk fat are incorporated in liquid suspension or solution, Ovaltine in milk is also especially adapted to liquid diets. The highly satisfying flavor makes for its ready acceptability when foods are often distasteful.

The important overall nutrient contribution of three glassfuls of Ovaltine mixed with milk is presented in the accompanying table.

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CALORIES	676	VITAMIN A	3000 I.U.
PROTEIN	32 Gm.	VITAMIN B_1	1.16 mg.
FAT	32 Gm.	RIBOFLAVIN	2.0 mg.
CARBOHYDRATE	65 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12 mg.	COPPER	0.5 mg.

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.



Birth-Death Registration Test Is On . . .

Census Takers Will Test Completeness of Registry in Ohio and Other States During Period January-March; Ohio Ranked Low in Last Test

THE completeness with which births and deaths in Ohio and other states are registered will be determined on the basis of such registrations during the period January, February and March, 1950. The last time such a test was made, Ohio ranked lowest in percentage of registrations of any of the Midwestern States.

The test will be made in conjunction with the decennial census which begins April 1, but will be a distinct report in itself. Each family will be asked if a birth or death occurred in the family during the period between January 1 and March 31, 1950. If the answer is affirmative, the enumerator will fill out a special form which will show information similar to that on a birth or death certificate. These special enumerators' reports will be sent to the National Office of Vital Statistics. During the same period the Division of Vital Statistics of the Ohio Department of Health will send in reports of each birth and death certificate filed with it for the same period. The census enumerators' reports will be matched with the reports from the Division of Vital Statistics and the number of unregistered births and deaths determined.

The unmatched reports will be returned to the Ohio Division of Vital Statistics to determine whether or not: (1) A delayed certificate has been received; (2) the birth or death occurred in Ohio; (3) the birth or death occurred during the test period; (4) the names on birth certificates had been legally changed.

From the unmatched returns the National office will determine the percentage of completeness of birth and death registrations for each city, county and state in the Nation.

OHIO LOW IN 1940

The same procedure was followed during the last census in 1940, except that the test was restricted to birth registrations. During that test it was determined that birth registrations in Ohio were only 95.6 per cent complete—the lowest percentage of any of the Midwestern States. That means that at that time approximately 5,000 births in Ohio had not been registered.

Health Department officials report that the percentage of unregistered births is much lower than it was ten years ago, but it is still far from 100 per cent. The war did much to stimulate more careful registration of births. Increasing demands for registered information have added to this stimulus. Here are some of the occasions for which birth certificates are required: Entrance to school, work permit, right to vote, right to marry, right to enter civil service, right to enter or be exempt from military service, settlement of pensions, determining eligibility of social security benefits to aged or dependent children, inheritance of property, legal dependency, etc., etc. Death certificates also play an important role in the lives of descendents and heirs.

Besides these considerations on the part of individuals, birth and death certificates play an all-important part in the establishment of medical information from vital statistics.

Death certificates do not give Vital Statistics personnel so much trouble. One reason for this is that funeral directors cannot obtain burial permits until deaths are registered. As a result in most areas morticians and physicians have worked out a routine for registration.

Most of the difficulty with birth certificates arises in home delivery cases. Most hospitals follow a routine in reporting births. However, in some instances hospital personnel have had excessive delays in getting doctors to sign birth certificates, health officials reported.

ONLY A FEW

The chief of Vital Statistics eagerly pointed out that the great majority of doctors cooperate 100 per cent in the prompt signing of certificates. This is borne out by the fact that approximately 6,500 death certificates and more than 15,000 birth certificates, each signed by a physician, come into the Vital Statistics office in Columbus every month.

On the other hand, if a thousand or so certificates fail to come in during the test period, Ohio may again rank low in registrations among comparable states.

While a period of grace is allowed during which delinquent certificates will be checked, health officials are urging that all who have any connection with the filing of certificates see that they are filed promptly.

Opinion of Attorney General

The syllabus of Opinion No. 1071, rendered by Attorney General Herbert S. Duffy, reads as follows:

"An X-ray technician appointed by a county coroner under authority of Section 2855-17 of the General Code, is not entitled to compensation for his services under Section 2855-18 of the General Code."

"The ... estrogen preferred by us is 'Premarin,' a mixture of conjugated estrogens, the principal one of which is estrone sulfate."

Hamblen, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

In treating the menopausal syndrome with "Premarin," Perloff* reports that "Ninety-five and eight tenths per cent of patients treated with 3.75 mg. or less daily obtained complete relief of symptoms"; also, "General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin.'"

Thus, the sense of "well-being" usually imparted represents a "plus" in "Premarin" therapy which not only gratifies the patient but is conducive to a highly satisfactory patient-doctor relationship.

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg. and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens...estradiol, equilin, equilenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.

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Feeling the Public's Pulse on Federal Health Plan

"The New Jersey Poll" conducted by the Princeton Research Service reported on December 22, 1949, that 46.6 per cent of New Jersey's adult population feel that the U. S Congress should pass the Truman compulsory health insurance plan. It was found, however, that 43.4 per cent of the people oppose this program and that 10 per cent are undecided.

"The New Jersey Poll" characterizes the margin of 3.2 per cent as "very narrow" and notes that all New Jersey poll survey findings are subject to an average error of four percentage points because of sampling variations.

Most emphatic support for the Truman plan is found in the biggest cities and among regular Democratic voters. Independent voters are opposed to compulsory health insurance by approximately the same margin as regular Republican voters.

URBAN, RURAL DIFFERENCES

In rural communities and in the medium sized towns, a clear majority appears to oppose compulsory insurance whereas in cities of 100,000 population or more, the vote runs nearly two to one in favor of this plan.

Younger people are much more likely to favor compulsory health insurance than those 45 years of age or more and, in general, the more education a person has the more likely he is to be opposed to compulsory health insurance.

White collar workers are opposed to the plan by a fairly appreciable margin, whereas manual workers favor it by a ratio of five to four.

Perhaps most surprising in view of the extensive union propaganda for compulsory health insurance is the finding that 51 per cent of labor union members favor it, 37 per cent do not, and 12 per cent are of no opinion.

OPINIONS ON HOSPITALS

An interesting correlation—*in reverse*—is found between the Poll report on compulsory health insurance and a similar report by the same organization issued on November 17 relating to the public attitude in New Jersey toward their community hospitals.

Statewide, the Poll found that 58 per cent of the people think that their local hospitals are good enough, 28 per cent are dissatisfied with them, and 14 per cent have no opinion. Least satisfaction is found in the rural areas and the greatest satisfaction in the larger cities.

The principal suggestions offered by dissatisfied voters concerned the alleged need for more personnel, for enlarged facilities, for building repairs, and for new hospitals generally. A number commented on the high cost of hospitalization and the "money on the line" attitude of some of the hospitals with which they have come in contact.

The New Jersey Poll has a remarkable record for accuracy whenever its findings have been tested by actual vote. It was uncannily accurate in the recent gubernatorial election even having made a daring advance prediction that Jersey City might go Republican!—*New Jersey Medical Society Membership News Letter.*

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since December 1, 1949. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

CUYAHOGA COUNTY

Herschel L. Browns, Lakewood
Frederick A. Rose, Cleveland
Elmer R. Swanson, Cleveland
Edward C. Weiford, Cleveland

STARK COUNTY

Edward P. Schneider, Canton

SUMMIT COUNTY

Devitt L. Gordon, Akron
Walter A. Hoyt, Jr., Akron
Edward Kope, Akron
Kazuo Tashiro, Mogadore

Procedure Outlined on X-rays Sent Industrial Commission

Each year the State Industrial Commission receives between 600 and 700 sets of X-ray films which cannot be processed for payment. In a majority of cases no claims have been filed. If no claims are filed within a reasonable time, the films are returned to the senders. A number of films cannot be identified because they are not properly marked.

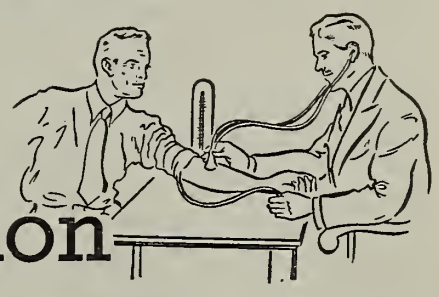
In the 30-day period, between November 19 and December 19, 1949, over 100 sets of such films were filed with the Commission. If this average continues, the loss to Ohio physicians will total many thousands of dollars.

In order to remedy this situation and expedite the payment of fee bills, the Commission recommends the following procedure in the submission of X-ray films:

No films should be filed unless the fee bill and interpretation, personally signed by the roentgenologist, accompany the film. Each individual film should be plainly marked, showing the claim number, claimant's name, doctor's name, and date of film.

Claim numbers can be secured from employers, who are promptly notified of numbers assigned as soon as claims are filed with the Commission. In cases where the employer has no record of a claim number, it is apparent no claim has been filed and the contact of the employer by the physician should expedite the filing of such claims.



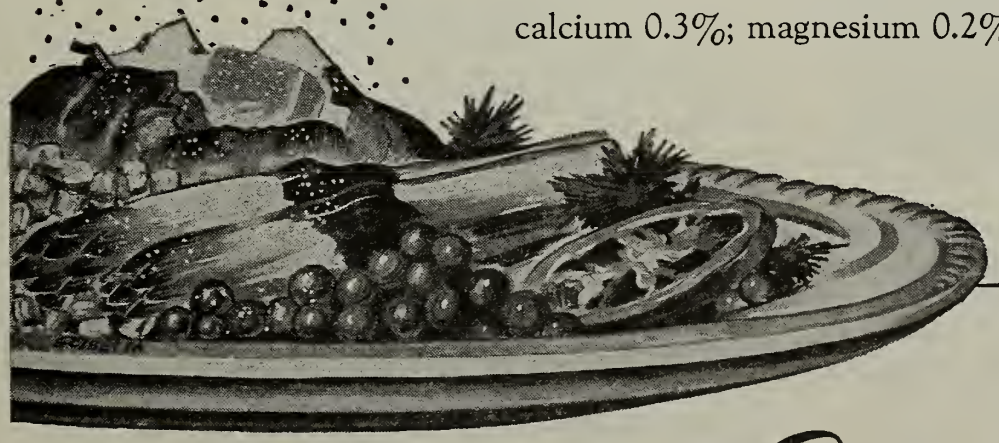


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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

ADAMS

Officers of the Adams County Medical Society for 1950 are the following: Dr. Samuel R. Gendelman, Manchester, reelected pres.; Dr. Robert B. Ellison, Peebles, vice-pres.; and Dr. Hazel L. Sproull, West Union, reelected secy.-treas. Delegate is Dr. S. J. Ellison, West Union, and the alternate is Dr. R. L. Lawwill, Seaman.

BROWN

Three Brown County physicians were presented the Ohio State Medical Association's 50-Year Pin and Certificate at a special meeting of the Brown County Medical Society. The three are Dr. George P. Tyler, Sr., Ripley; Dr. H. P. Shelton, Georgetown; and Dr. S. A. Laughlin, Aberdeen. Dr. William L. Faul of Georgetown, president, presided at the meeting while Dr. David W. Heusinkveld, Cincinnati, Councilor of the First District, made the presentations.

BUTLER

Officers of the Butler County Medical Society for the year are Dr. Louis H. Skimming, Middletown, pres.; Dr. Paul C. Schumacher, Hamilton, pres.-elect; and Dr. John A. Carter, Middletown, secy.-treas. Delegates are Dr. Neil Millikin, Hamilton, and Dr. Charles Atkinson, Middletown; alternates, Dr. John F. Borelli, Hamilton, and Dr. William U. Neel, Middletown.

CLERMONT

The following officers of the Clermont County Medical Society took office on Nov. 16: Dr. A. A. Gruber, Bethel, pres.; Dr. Charles B. Armstrong, Loveland, vice-pres.; Dr. J. M. Coleman, Loveland, secy.-treas. Dr. Coleman also was elected delegate and Dr. Gruber, alternate.

CLINTON

The following officers of the Clinton County Medical Society were elected or reelected at the Dec. 6 meeting: Dr. R. H. Vance, pres.; Dr. H. R. Bath, vice-pres.; and Dr. R. W. DeCrow, secy.-treas. Dr. E. K. Yantes was elected delegate and Dr. R. R. Buchanan, alternate. All are of Wilmington.

The Jan. 10 meeting of the Society was held at the General Denver Hotel. A discussion was held on forming a Tri-County Society with Fayette and Highland Counties. Dr. Robert G. Claeys, Lynchburg, secy.-treas. of the Highland County Society was a visitor.

HAMILTON

Dr. George X. Schwemlein has been named editor-in-chief of the revamped journal of the Academy of Medicine of Cincinnati. Serving with him as members of the editorial board are: Dr. William F. Ashe, Dr. Lester J. Bossert, Dr. Robert W. Boyle, Dr. Robert W. Buckley, Dr. Roy L. Kile, Dr. Elmer Maurer, Dr. Kurt Tchiassney, Dr. Carl F. Vilter and Dr. F. William Vockell. The historical *Journal of the Academy of Medicine of Cincinnati* was discontinued in its old form after the December issue.

At the Jan. 3 meeting of the Academy, Dr. Jacob E. Finesinger, University of Maryland, Baltimore, spoke on "The Psychiatric Aspects of Fatigue."

HIGHLAND

Highland County Medical Society officers for the year 1950 are the following: Dr. John G. Anderson, Lynchburg, pres.; Dr. Walter Felson, Greenfield, vice-pres.; Dr. Robert G. Claeys, Lynchburg, secy.-treas. Dr. J. Martin Byers, Greenfield, is delegate and Dr. Leland D. McBride, Hillsboro, is alternate.

WARREN

The following officers of the Warren County Medical Society were elected for 1950: Dr. Frank L. H. Batsche, Mason, pres.; Dr. A. G. Steele, Loveland, vice-pres.; Dr. John DeBold, Morrow, secy.; and Dr. Mary Cook, Waynesville, treas. Dr. Orville L. Layman, Franklin, was elected delegate and Dr. Alfred E. Stout, Waynesville, alternate.

Dr. Leonard Mounts of Morrow was honored at a banquet meeting of the Warren County Medical Society on Dec. 18 at the Golden Lamb. He was presented the Ohio State Medical Association's 50-Year Pin and Certificate by Dr. O. L. Layman, president of the Society. Dr. Mounts has served his entire professional career in Morrow.

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CHAMPAIGN

Champaign County Medical Society officers who took office on January 1 are: Dr. Lewis C. Inskeep, pres.; Dr. Isador Miller, vice-pres.; and Dr. F. R. Grogan, secy.-treas. Dr. D. C. Houser again was elected delegate and Dr. E. R. Earle, alternate. All are of Urbana. Guest speaker at the December meeting was Mrs. Bernice Price, county welfare department director.

CLARK

Dr. H. H. Ingling assumed office as president of the Clark County Medical Society on January 1. Officers elected include Dr. Ray M. Turner, pres.-elect; Dr. W. K. Lehmann, secy.; and Dr. George A. Smith, treas. Dr. Turner also

was elected delegate, and Dr. S. C. Yinger, alternate. All are of Springfield.

At the Jan. 16 meeting, Dr. George Crile, Jr., Cleveland, spoke on the subject, "Present Trends in the Diagnosis and Surgical Treatment of Abdominal Disease."

DARKE

Darke County Medical Society officers for the year are: Dr. Paul G. Lenhert, Arcanum, pres.; Dr. J. W. VanLue, Gettysburg, vice-pres., and Dr. Maurice M. Kane, Greenville, secy.-treas. Dr. J. E. Gillette, Versailles, and Dr. Gilbert E. Sayle, Greenville, are delegate and alternate, respectively.

GREENE

Five Xenia physicians were elected as officers and representatives of the Greene County Medical Society. They are Dr. Ray W. Barry, pres.; Dr. C. G. McPherson, vice-pres.; and Dr. R. D. Hendrickson, secy.-treas. Dr. H. C. Messenger was elected delegate and Dr. Paul D. Espey, alternate. The society engaged as executive secretary Mr. Frank Bateman of Springfield who also will serve as associate editor of a society bulletin. Mr. Bateman performs similar activities for the Clark County and Butler County Medical Societies.

MIAMI

Dr. W. W. Trostle, Piqua, and Dr. G. A. Woodhouse, Pleasant Hill, were reelected president and secy.-treas., respectively, of the Miami County Medical Society at the annual meeting held on Dec. 2. The new vice-president is Dr. K. F. Lowry, Troy. Dr. Woodhouse again was elected delegate and Dr. Harry Schilling, Troy, was elected alternate.

MONTGOMERY

Dayton physicians who were elected officers of the Montgomery County Medical Society and took office Jan. 1 are: Dr. H. D. Cassel, pres.; Dr. F. H. Miller, vice-pres.; Dr. H. M. James, pres.-elect; Dr. Paul Troup, secy.; and Dr. W. A. Reiling, treas. Delegates are Dr. R. S. Binkley, Dr. A. W. Carley, Dr. R. D. Dooley and Dr. T. L. Light.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D., UPPER SANDUSKY)

ALLEN

Dr. H. L. Basinger is the incoming president of the Allen County Medical Society for the ensuing year. Other officers are: Dr. Alfred W. Pinkerton, pres.-elect; Dr. Richard L. Johnson, secy.; and Dr. J. W. Burke, treas. The delegate and alternate respectively are Dr. F. P. Berlin and Dr. R. L. Tecklinberg. All are of Lima.

Dr. Ezra Burnett of Delphos was presented the 50-Year Pin and Certificate of the Ohio State Medical Association at a special ceremony held in December. He has practiced for about seven years at Wetzel before moving to Delphos in 1900.

AUGLAIZE

Officers of the Auglaize County Medical Society were reelected for the ensuing year. They are Dr. Elizabeth Kuffner, St. Marys, pres.; Dr. W. F. Schmiesing, Minster, secy.-treas. Dr. C. W. Berry, Wapakoneta, is the new delegate and Dr. R. S. Oyer, also of Wapakoneta, continues as alternate.

CRAWFORD

Officers of the Crawford County Medical Society for 1950 are: Dr. D. D. Bibler, pres.; Dr. K. H. Barth, vice-pres.; and Dr. Donald R. Wenner, secy.-treas. The delegate is Dr. John S. Kiess and the alternate Dr. Jack W. Arnold. Dr. Barth is of New Washington; the others of Bucyrus.

Four Crawford County doctors were honored at a dinner meeting of the Crawford County Medical Society in Galion. They are Dr. W. H. Guiss, Tiro; Dr. H. H. Hartmann, Galion; Dr. E. R. Schoolfield, Bucyrus; and Dr. C. A. Marquart, Crestline. The 50-Year Pin and Certificate of the Ohio State Medical Association was presented to each by Dr. J. Craig Bowman, Upper Sandusky, Councilor of the Third District. Dr. Martin L. Helfrich, Galion, president of the Society, presided. Guest speaker for the occasion was Kenneth M. Petri, Galion attorney and former State representative of Crawford County.

HANCOCK

The following officers were elected by the Hancock County Medical Society and took office on Dec. 14: Dr. Harold K. Treece, Arlington, pres.; Dr. T. R. Shoupe, Findlay, vice-pres.; Dr. Grant Janes, Findlay, secy.; and Dr. David Greegor, Findlay, treas. Delegate and alternate, respectively, are Dr. Frank M. Wiseley, Findlay, and Dr. Treece. Scientific speaker at the December meeting was Dr. Robert McArthur, Wayne University College of Medicine, Detroit, who spoke on "Other Diseases of the Body Simulating Kidney Tract Disease."

HARDIN

Dr. George M. Mason, Mt. Victory, was presented the 50-Year Pin and Certificate at a special meeting of the Hardin County Medical Society and the Auxiliary. Dr. Mason moved to Mt. Victory about seven years ago. He formerly practiced also in Washington County and in Noble County where he was health commissioner for a number of years.

LOGAN

The following officers were elected in the Logan County Medical Society for 1950: Dr. C. K. Startzman, Bellefontaine, pres.: Dr. Hobart L. Mikesell, West Liberty, vice-pres.; Dr. F. Blair

Webster, Bellefontaine, secy.-treas. Dr. Warren F. Mills, Bellefontaine, was elected alternate delegate.

Dr. O. W. Loffer, DeGraff, was honored in December by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association.

MARION

At the annual business meeting of the Marion County Academy of Medicine held on Dec. 13, Dr. R. T. Gray, Prospect, was elected and installed as president. Other officers are Dr. F. T. Merchant, vice-pres., and Dr. William Leffler, secy.-treas., both of Marion. Included in business discussed at the meeting was that of opening a Well-Baby Clinic in Marion County for the examination of indigent infants and children.

MERCER

Dr. R. G. Schmidt, Celina, was reelected president of the Mercer County Medical Society for 1950. Other officers are Dr. E. J. Willke, Maria Stein, vice-pres.; and Dr. John W. Chrispin, Lockford, acting secy. and treasurer. Delegate and alternate, respectively, are Dr. L. M. Otis and Dr. Ralph J. Beare, both of Celina.

SENECA

The following officers were elected by the Seneca County Medical Society for 1950: Dr. W. R. Funderburg, pres.; Dr. Avery D. Powell, vice-pres.; and Dr. Walter A. Daniel, secy.-treas. Dr. R. F. Machamer was elected delegate and Dr. Paul J. Leahy, alternate. All are of Tiffin.

VAN WERT

The following Van Wert physicians were elected as officers of the Van Wert County Medical Society and took office Dec. 13: Dr. R. E. Shell, pres.; Dr. W. C. Scheidt, vice-pres.; and Dr. T. L. Edwards, secy.-treas. Dr. Shell also was elected delegate and Dr. Edwards, alternate.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

FULTON

Members of the Fulton County Medical Society elected the following officers who took office on Dec. 13: Dr. Ralph W. Reynolds, Fayette, pres.; Dr. C. F. Murbach Archbold, vice-pres.; and Dr. Paul I. Geer, Metamora, secy.-treas. The elected delegate is Dr. E. R. Murbach, Archbold, and the alternate, Dr. R. E. Merrill, Delta.

HENRY

The following Napoleon physicians were elected to office in the Henry County Medical Society for the ensuing year: Dr. Thomas Quinn, pres.; Dr. J. R. Bolles, vice-pres., and Dr. John R. Schlereth, secy.-treas. Dr. B. L. Johnson, Deshler, is the society's delegate, and Dr. Quinn is alternate.

LUCAS

The following programs were included in the schedule of the Academy of Medicine of Toledo and Lucas County for December:

General Meeting, Dec. 2—"Legal and Practical Aspects of Mal-Practice," Mr. Charles W. Peckinpaugh, Jr., Toledo attorney.

Section on Pathology, Experimental Medicine and Bacteriology, Dec. 9—"Investigations of Bone Marrow in the Control of Blood Cells," Dr. Bernhard Steinberg, Toledo.

OTTAWA

The following officers of the Ottawa County Medical Society were elected to serve during 1950: Dr. H. O. Beeman, pres.; Dr. Gordon R. Ley, vice-pres.; and Dr. James I. Rhiel, secy.-treas., all of Port Clinton. Elected delegate and alternate, respectively, are Dr. G. A. Boon, Oak Harbor, and Dr. C. R. Wood, Port Clinton.

PAULDING

At the regular meeting of the Paulding County Medical Society in November the following officers were elected for 1950: Dr. K. C. Evans, Payne, pres.; Dr. W. H. Caine, Antwerp, vice-pres.; and Dr. J. M. Poitras, Antwerp, secy.-treas.

PUTNAM

Members of the Putnam County Medical Society at their December meeting elected the following officers: Dr. M. W. Palestrant, Continental, pres.; Dr. D. B. Lucas, Columbus Grove, vice-pres.; Dr. C. J. Heitz, Ft. Jennings, secy.; and Dr. H. N. Trumbull, Columbus Grove, corresponding secy.

SANDUSKY

Dr. Harold L. Keiser, Fremont, was elected president of the Sandusky County Medical Society at its December meeting. Other officers named for the current year are Dr. F. A. Visconti, vice-pres., and Dr. Ervin L. Koons, secy.-treas., both of Fremont. The December meeting was held in conjunction with a Fourth District meeting of the Academy of General Practice.

WILLIAMS

Members of the Williams County Medical Society elected the following officers for the year which began Dec. 15: Dr. Paul G. Meckstroth, Bryan, pres.; Dr. William L. Hann, West Unity, vice-pres.; and Dr. Irving L. Colvin, Edon, secy.-treas. The elected delegate and alternate are Dr. H. R. Mayberry, and Dr. R. A. Gilreath, respectively, both of Bryan.

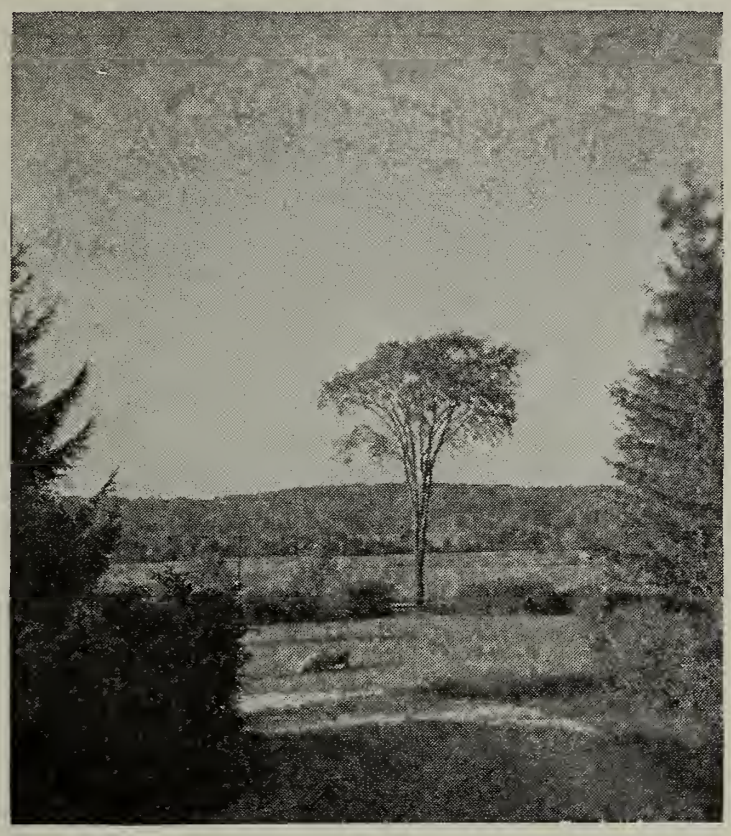
WOOD

The Wood County Medical Society held its regular dinner meeting at the Midway Restaurant, Dixie Highway, Perrysburg, Dec. 15.

At the short business session the following officers were installed for the year of 1950. Dr. Ray Whitehead, Bowling Green, pres.; Dr. James

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R. McAuley, Perrysburg, vice-pres.; and Dr. Roger Peatee, Bowling Green, secy.-treas.

The paper of the evening was given by Dr. George P. Hohley, Coroner of Lucas County, entitled "A Coroner Looks at Life." This was a different type of paper from that usually presented at medical meetings, but with Dr. Hohley's long experience in forensic medicine it was informative and thought provoking.

After reviewing the history of the office and commenting on routine procedure Dr. Hohley pointed out some of the hazards not usually recognized—for instance, death from vitamins, from barbiturates and alcohol. He commented on the newer scientific methods of determining the causes of death and of the very good facilities in Ohio.

Malnutrition, particularly in the aged, came in for mention as seen in some convalescent homes.

A rising vote of thanks was tendered Dr. Hohley.

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

ASHTABULA

Incoming officers of the Ashtabula County Medical Society for the year which began Dec. 13 are the following: Dr. C. T. Risley, Conneaut, pres.; Dr. William H. Eberle, Ashtabula, vice-pres.; and Dr. R. C. Irving, Conneaut, secy.-treas. Dr. M. R. Martin, Geneva, was elected delegate and Dr. P. J. Collander, Ashtabula, alternate.

GEAUGA

Geauga County Medical Society officers for the year which began Oct. 27 are: Dr. W. C. Cory, Chardon, pres.; Dr. G. D. Chirelli, Parkman, vice-pres.; and Dr. Isa Teed Crampton, Burton, secy.-treas. Dr. Phillip P. Pease, Chardon, is delegate, and Dr. Alton W. Behm, also of Chardon, alternate.

LAKE

Dr. Paul E. Reading, Painesville, was named president of the Lake County Medical Society. Dr. Thomas E. Byrne, Mentor, is the vice-pres., and Dr. R. Keith Miles, Madison, secy.-treas. Delegate and alternate, respectively, are Dr. Morris G. Carmody and Dr. B. S. Park, both of Painesville.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

COLUMBIANA

Members of the Columbiana County Medical Society elected the following Salem physicians as officers for 1950: Dr. R. J. Starbuck pres.; Dr. R. J. McConnor, vice-pres., and Dr. H. F. Hoprich, secy.-treas.

MAHONING

Mahoning County Medical Society members elected the following officers who took office on Dec. 20: Dr. Gordon C. Nelson, pres.; Dr. E. J. Wenaas, vice-pres.; Dr. G. E. DeCicco, secy.; and Dr. L. H. Getty, treas. Delegates are Dr. V. L. Goodwin and Dr. C. A. Gustafson; alternates, Dr. R. E. Odom and Dr. J. C. Vance. Dr. Vance resides in Poland; the others in Youngstown.

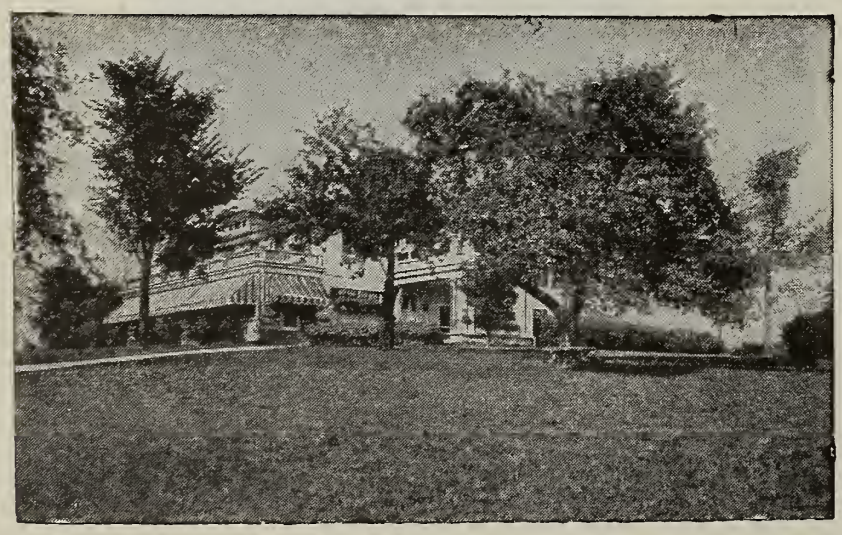
PORTAGE

Members of the Portage County Medical Society elected the following officers who took office at the first of the year: Dr. Myron W. Thomas, Garrettsville, pres.; Dr. Robert M. Dumm, Kent, vice-pres.; and Dr. Edgar A. Knowlton, Mantua, secy.-treas. Delegate and alternate, respectively, are Dr. Dumm and Dr. R. C. Neely, Ravenna.

Dr. J. H. Krape, practicing physician in Kent for approximately 56 years, was honored at a meeting of the Portage County Medical Society on Jan. 5. Dr. Paul A. Davis, Akron, Councilor of the Sixth District of the Ohio State Medical Association, presented the 50-Year Pin and Certificate.

STARK

Officers of the Stark County Medical Society who took office on Dec. 8 are the following; Dr. Ian B. Hamilton, pres.; Dr. L. E. Anderson,



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pres.-elect; Dr. J. L. Yahraus, secy.-treas. Delegate and alternate, respectively, are Dr. John E. Dougherty and Dr. A. A. Lichtblau. All are of Canton except Dr. Anderson who resides in Greentown.

SUMMIT

Dr. John D. Brumbaugh assumed office as president of the Summit County Medical Society at the Jan. 3 meeting. Other officers are Dr. Louis A. Witzeman, pres.-elect; Dr. Donald I. Minnig, secy.; and Dr. Arthur F. Dorner, treas. Delegates are the following: Dr. Kurt Weidenthal, Dr. C. A. Raymond, Dr. E. W. Burgner and Dr. F. T. Moore. Alternates are Dr. W. T. Bucher, Dr. J. W. Ewing, Dr. R. G. McCready and Dr. R. H. Wilson. Except Dr. Weidenthal, a Hudson resident, the foregoing are Akron physicians.

TRUMBULL

Dr. E. G. Caskey, Mineral Ridge, is the new president of the Trumbull County Medical Society. Dr. J. M. Gledhill, Warren, is vice-pres. and Dr. C. W. Mathias, Niles, is secy.-treas. Delegate and alternate, respectively, are Dr. Densmore Thomas, Niles, and Dr. S. J. Shapiro, Warren.

Seventh District

(COUNCILOR: R. J. FOSTER. M. D., NEW PHILADELPHIA)

BELMONT

Belmont County Medical Society officers for the year beginning January 1 are: Dr. Harvey H. Murphy, Barnesville, pres.; Dr. David Danenberg, Bridgeport, vice-pres.; and Dr. Bertha M. Joseph, Martins Ferry, secy.-treas. Dr. Murphy also was elected delegate and Dr. Danenberg, alternate.

CARROLL

Dr. John H. Murray, Carrollton, was elected president of the Carroll County Medical Society for the year beginning Jan. 1. Dr. Joseph D. Stires, Malvern, is the vice-pres., and Dr. Charles H. Dowell, Carrollton, secy.-treas. Delegate and alternate respectively are Dr. W. G. Lyle, Minerva, and Dr. Glenn C. Dowell, Carrollton.

COSHOCTON

The Coshocton County Medical Society elected the following officers for 1950: Dr. George D. Mogil, pres.; Dr. J. C. Briner, vice-pres.; and Dr. H. W. Lear, secy.-treas. Dr. E. J. Booth was elected delegate and Dr. F. W. Craig, alternate. All are of Coshocton except Dr. Briner who is of West Lafayette.

HARRISON

President of the Harrison County Medical Society for 1950 is Dr. D. L. Tippett, Cadiz. Dr. G. E. Vorhies, Scio, is vice-president, and Dr. Richard W. Weiser, Jewett, secy.-treas. Dele-

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gate and alternate are Dr. C. F. Goll, Hopedale, and Dr. Tippett, respectively.

JEFFERSON

The following Steubenville physicians were elected to office in the Jefferson County Medical Society for 1950: Dr. S. L. Burkhardt, pres.; Dr. Warren G. Snyder, vice-pres.; and Dr. Sanford Press, secy.-treas. Dr. John F. Gallagher was named delegate and Dr. Burkhardt, alternate.

TUSCARAWAS

Members of the Tuscarawas County Medical Society elected the following officers who took office on Jan. 1: Dr. William E. Hudson, New Philadelphia, pres.; Dr. Vincent C. Nipple, Midvale, vice-pres.; and Dr. Harold F. Wherley, New Philadelphia, secy.-treas. Dr. J. S. Adler, Strasburg, is delegate, and Dr. E. C. Davis, Jr., Dover, is alternate.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M. D., LANCASTER)

ATHENS

The new president of the Athens County Medical Society is Dr. M. H. Mitchell, Albany. Dr. A. A. Baldwin, Athens, is the new vice-president and Dr. C. R. Hoskins, Athens, secy.-treas. Delegate and alternate respectively are Dr. Beatrice Postle, Athens, and Dr. M. H. Mitchell, Albany. Officers were elected at a dinner meeting Dec. 13 at which guest speaker was Dr. Frank W. Lowenstein, medical director of the Athens County Nutrition and Health Survey.

GUERNSEY

Dr. Reo. M. Swan, Cambridge, took office as president of the Guernsey County Medical Society on Jan. 1. Other officers are Dr. J. D. Knapp, Cambridge, vice-pres., and Dr. F. Gordon Lawyer, Cambridge, secy.-treas. Dr. Robert A. Ringer of Cambridge is delegate and Dr. Benjamin S. Gillespie, Senecaville, alternate.

Thirteen members and one guest were present at the Jan. 5 meeting at the Berwick Hotel. Dr. Kenneth J. Frakes was the guest. New committee members were announced. A letter was read from Dr. E. J. Farrell, Jr., who is taking residency training at Louisville, Ky.

It was moved by Dr. Denny and seconded by Dr. Wells that "this society go on record as requesting an explanation by the A. M. A. as to why those who contributed their $25 donation to the A. M. A. last year should not be given credit for this, against the $25 to be levied against them this year, so as to put one and all on a fair and equitable basis." After discussion

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the motion carried six to two, some members not voting.

The scientific portion of the program was in charge of Dr. Lawyer who spoke on "Newer Developments in Dermatology," based on discussions at the recent meeting of the American Academy of Dermatology and Syphilology in Chicago.

Members of the Society entertained their wives and other guests at a holiday program at the Berwick Hotel, arranged by Dr. Lawyer and Dr. M. C. McCluskey.

MUSKINGUM

Dr. James E. McCormick was elected president of the Muskingum Academy of Medicine at the annual banquet on Dec. 2. Other officers named are: Dr. D. K. Matthews, Dresden, vice-pres.; Dr. W. W. Renner, Zanesville, secy.-treas. Dr. George C. Malley was named delegate and Dr. Paul A. Jones, alternate, both of Zanesville.

NOBLE

Dr. Charles F. Thompson was reelected president of the Noble County Medical Society for 1950. Other officers are Dr. N. S. Reed, vice-pres., and Dr. Edward G. Ditch, secy.-treas. Dr. Ditch also was elected delegate and Dr. Reed, alternate. All are of Caldwell.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

GALLIA

The following Gallipolis physicians were elected to office in the Gallia County Medical Society for 1950: Dr. Homer B. Thomas, pres., and Dr. J. Gordon Gibert, secy.-treas. Dr. Charles E. Holzer, Jr., was chosen delegate and Dr. Jacob Weinberger, alternate.

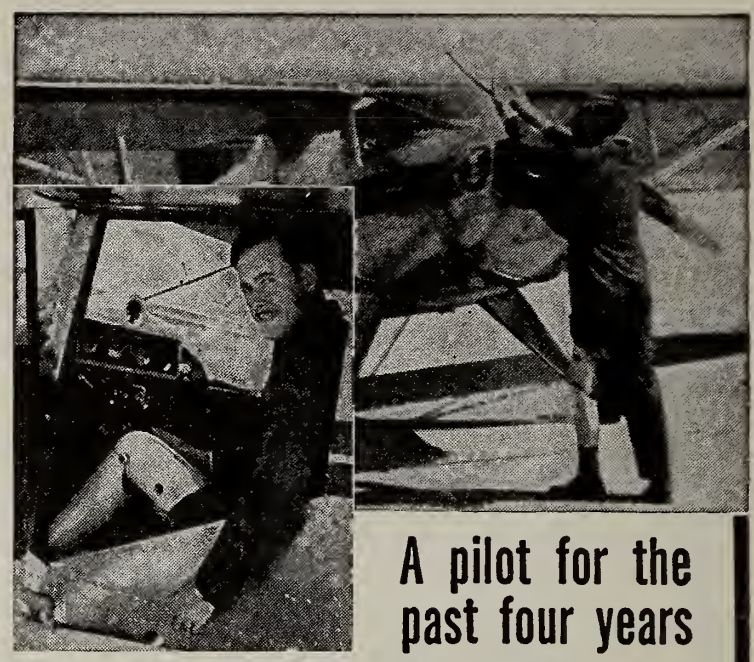
Dr. Ella G. Lupton was honored by a banquet sponsored by the Gallia Society on Dec. 28, at which time she was presented the 50-Year Pin and Certificate of the Ohio State Medical Association. The presentation was made by Dr. N. Howard Foster, retiring president. Leading citizens in addition to members of the Society joined in the banquet honoring Dr. Lupton who is 87 years old.

JACKSON

Dr. J. S. Hunter, Jackson, was presented the 50-Year Pin and Certificate of the Ohio State Medical Association at the meeting of the Jackson County Medical Society early in December. A veteran of World War I, Dr. Hunter is still practicing at the age of 84.

LAWRENCE

Dr. Anne-Marting Alstott was elected president of the Lawrence County Medical Society with the following other officers: Dr. Charles H. Ross, vice-pres., and Dr. G. Newton Spears, secy.-treas. Delegate and alternate are Dr.



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Spears and Dr. George G. Hunter, respectively. All are of Ironton.

SCIOTO

The Hempstead Academy of Medicine elected the following officers and representatives for the year 1950: Dr. L. B. Hatch, South Webster, pres.; Dr. R. L. Wagner, Portsmouth, vice-pres.; Dr. C. L. Pitcher, Portsmouth, secy.-treas.; Dr. O. D. Tatje, Portsmouth, delegate; and Dr. W. M. Singleton, West Portsmouth, alternate.

VINTON

Dr. Richard E. Bullock and Dr. Herbert D. Chamberlain of McArthur, were reelected president and secy.-treas., respectively, of the Vinton County Medical Society. Dr. Chamberlain also was elected delegate and Dr. Bullock alternate.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M. D., COLUMBUS)

DELAWARE

Dr. B. R. Lauer is president of the Delaware County Medical Society for the ensuing year. Dr. G. E. Robinson is vice-pres., and Dr. F. M. Stratton, secy.-treas. Delegate and alternate, respectively, are Dr. George J. Parker and Dr. Edward C. Jenkins. Dr. Robinson is of Ostrander; the others of Delaware.

PICKAWAY

The following Circleville physicians were elected officers of the Pickaway County Medical Society for 1950: Dr. H. D. Jackson, pres.; Dr. Lloyd Jonnes, vice-pres.; and Dr. Walter F. Heine, secy.-treas. Dr. E. L. Montgomery is delegate, and Dr. E. S. Shane, alternate.

ROSS

The following Chillicothe physicians were elected officers and representatives of the Ross County Medical Society and took office Dec. 1: Dr. Edwin H. Artman, pres.; Dr. Francis W. Nusbaum, pres.-elect; Dr. Richard L. Counts, secy.-treas.; Dr. Ralph W. Holmes, delegate, and Dr. Harold M. Crumley, alternate.

UNION

Union County Medical Society officers for the year which began on Dec. 13 are the following of Marysville: Dr. J. M. Snider, pres.; Dr. Paul R. Zaugg, vice-pres.; and Dr. Malcolm MacIvor, secy.-treas.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

ERIE

The following Sandusky physicians were elected officers of the Erie County Medical Society for the year which began Dec. 15: Dr. Charles J. Reichenbach, pres.; Dr. Duane D. Love, vice-pres.; and Dr. Arthur G. Groscost, secy.-treas. Dr. Ross M. Knoble was designated delegate and Dr. H. W. Lehrer, alternate.

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GYNECOLOGY—Intensive Course, two weeks, starting Feb. 20, Mar. 20. Vaginal Approach to Pelvic Surgery, one week, starting Mar. 6.

OBSTETRICS—Intensive Course, two weeks, starting Mar. 6, April 3.

PEDIATRICS—Intensive Course, two weeks, starting April 3. Personal Course in Cerebral Palsy, two weeks, starting July 31.

MEDICINE—Intensive General Course, two weeks, starting April 24. Electrocardiography & Heart Disease, four weeks, starting Mar. 13. Hematology, one week, starting May 8. Gastro-Enterology, two weeks, starting May 15. Liver & Biliary Diseases, one week, starting June 5. Gastroscopy, two weeks, starting Mar. 6, May 15.

DERMATOLOGY—Formal Course, two weeks, starting May 8. Informal Clinical Course, every two weeks.

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HURON

The fourth quarterly meeting of the Huron County Medical Society was held at Norwalk on Dec. 14. Dr. Clyde J. Cranston, Wakeman, was named for his third consecutive term as president; Dr. William W. Corwin, Willard, was voted vice-president; and Dr. George F. Linn, Norwalk, was reelected for his seventh consecutive term as secretary-treasurer. Delegate and alternate, respectively, are Dr. Owen J. Nicholson, Norwalk, and Dr. William H. Kauffman, Willard. Dr. C. L. Hannum, Plymouth, gave an illustrated lecture on "Regional Anesthesia."

LORAIN

Members of the Lorain County Medical Society elected the following officers who took office on Dec. 13: Dr. Swen D. Nielsen, Elyria, pres.; Dr. Henry C. Marsico, Lorain, vice-pres.; Dr. L. H. Trufant, Oberlin, secy.-treas. Dr. Leonard Stack, Lorain, and Dr. Russell Arnold, Avon, were elected delegates, and Dr. Anthony Piraino, Oberlin, and Dr. George R. Wiseman, Amherst, alternates.

Also at the Dec. 14 meeting of the Society, Dr. John S. Hattery, Mansfield, Councilor of the Eleventh District of the Ohio State Medical Association, made an official presentation of 50-Year Pins and Certificates to eligible physicians, none of whom was able to be present at the meeting. The physicians honored are Dr. H. J. Austin and Dr. George Gill, of Elyria; Dr. F. B. Gregg, Wellington; Dr. O. B. Monosmith, Lorain; and Dr. S. V. Burley, Lorain (since deceased); and posthumously to Dr. Emil Heinig, late of Vermillion.

MEDINA

Dr. Louis L. Zwick, Wadsworth, is the new president of the Medina County Medical Society for the year. Other officers are Dr. T. V. Kolb, Litchfield, vice-pres.; and Dr. Morris M. Malmud, Sharon Center, secy.-treas. Delegate and alternate, respectively, are Dr. William Dwyer and Dr. A. J. Karson, both of Medina.

RICHLAND

The December meeting of the Richland County Medical Society was held Dec. 22, at which time the following officers were elected for 1950: Dr. R. D. Campbell, Mansfield, pres.; Dr. F. M. Wadsworth, Mansfield, vice-pres.; Dr. Charles O. Butner, Shiloh, secy.-treas. Delegate and alternate, respectively, are Dr. P. A. Blackstone, Belleville, and Dr. W. H. Buker, Mansfield.

Dr. John S. Hattery, Councilor of the Eleventh District of the Ohio State Medical Association, presented Fifty-Year Pins and Certificates to Dr. R. R. Black, Dr. J. L. Stevens, Dr. L. A. Smith, Dr. J. M. Garber and Dr. J. A. Yoder, all of Mansfield, and Dr. G. J. Searle, Sr., of Plymouth. Dr. Searle and Dr. Yoder were unable to attend the meeting. The four doctors present for the awards made a few brief informal re-

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marks concerning their many years of medical practice. Four of these men, Drs. Black, Garber, Smith and Stevens, are still in active practice, making rounds at the hospital, having regular office hours, and making house calls, officers of the Society reported.

WAYNE

The following Wooster physicians were elected as officers and representatives of the Wayne County Medical Society: Dr. John B. Beeson, pres.; Dr. Richard N. Smith, vice-pres.; Dr. R. C. Paul, secy.-treas.; and Dr. L. L. Moore, assistant secy.; Dr. Layman A. Adair, delegate, and Dr. Harold G. Beeson, alternate. At the age of 88, Dr. Paul was elected secretary-treasurer for the 28th consecutive year.

Woman's Auxiliary . . .

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On Tuesday, March 14, a conference of presidents, secretaries, legislative chairmen and public relations chairmen of county Woman's Auxiliaries, also key state officers of the Auxiliary will be held in the Fort Hayes Hotel, 31 W. Spring St., Columbus, under sponsorship of the Ohio State Medical Association. Attendance will be by invitation.

BELMONT

The Belmont Hills Country Club was the scene on Dec. 20 of the annual Christmas party of the Auxiliary to the Belmont County Medical Society. Members brought gifts for distribution at the county infirmary and donated money for Christmas treats to be purchased for the patients at the county tuberculosis sanatorium. Following the business session, the women joined their husbands for a dinner-meeting and heard Representative Wayne T. Hayes, guest speaker, give an interesting account of a recent trip to Europe.

CUYAHOGA

The Woman's Auxiliary to the Cleveland Academy of Medicine plans to repeat this year, for the third consecutive time, its $25 merit award to one outstanding student in the junior class of each of the eleven Greater Cleveland schools of nursing.

There was a record gathering of Auxiliary members in October at Halle's Auditorium when Mrs. Paul C. Craig, chairman of public relations for the Woman's Auxiliary to the American Medical Association, spoke on "The Doctor's Wife in the Community." Mrs. D. M. Keating, president, presided at this meeting. Tea was served later, with Mrs. Charles A. Obert and her hospitality committee in charge of arrangements. The Cuyahoga County Auxiliary has three or four meetings a year of the entire

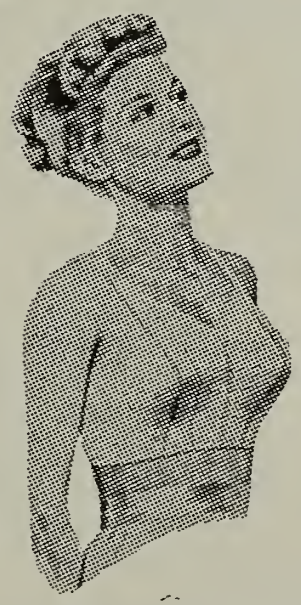
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ERIE

The Erie County Auxiliary extended a note of Christmas cheer to the nurses and personnel of Good Samaritan and Providence Hospitals when it entertained with a tea at the Business Women's Club on Dec. 12.

A musical program was presented during the afternoon by Miss Virginia Beuthel, young pianist, and Miss Darlene Miller, soprano. Mrs. C. E. Swanbeck, Mrs. C. J. Reichenbach, Mrs. Ross Knoble and Mrs. E. J. Meckstroth presided at the tea table. Mrs. Fred Schoepfle was chairman of hostesses.

FAIRFIELD

The Auxiliary to the Fairfield County Medical Society held its annual Christmas party for members and their husbands on Dec. 15. Dinner was served at the Lancaster Country Club.

HURON

A luncheon meeting was held on Dec. 9 by the Huron County Auxiliary in the Maple Room of the Greenwich Hotel. This was the third meeting of the Huron Auxiliary since its inception in the fall. Mrs. A. H. Kimmel is president. The group's regular meeting date is the second Friday of each month.

LUCAS

December was a comparatively quiet month for the Toledo and Lucas County Auxiliary, with the exception of the study groups which met during the month. The Legislative Workshop ended its series with the Dec. 5 meeting; but the group on "Child Development" and the group on "Live Issues of Today" continue their programs. A new course on Art Appreciation was scheduled to start Jan. 13.

The "Child Development" group, whose leader is Mrs. W. W. Green, held its January meeting at the home of Mrs. Oliver E. Todd. The topics discussed were "Developing Initiative" and "Educating for Competence."

The "Live Issues of Today" group met on Jan. 4. This group continued its discussion on how to ward off a Welfare State and also discussed "Devaluation of the British Pound."

For Feb. 11 the Academy and the Auxiliary have scheduled a supper dance at the Commodore Perry Hotel. Mrs. James McAuley, social chairman, is in charge of arrangements.

MONTGOMERY

The Woman's Auxiliary to the Montgomery County Medical Society held its Christmas meeting on Dec. 13 at the Dayton Art Institute. This was a luncheon meeting, with an attendance of 70. Following the luncheon, a skit "Medicine Marches On" was presented, illustrating the doctor's office of yesterday, the present, and what would take place in a "socialized medicine" office.

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OTTAWA

The Ottawa County Woman's Auxiliary met on Dec. 15 at the home of Mrs. Gordon Ley. Mrs. E. D. Schuiteman is a new member. Mrs. George Boone was named delegate and Mrs. George Poe alternate to the state auxiliary convention to be held in May.

After the business meeting, the doctors joined their wives for a gift exchange and social hour.

SANDUSKY

The annual Christmas party of the Sandusky County Auxiliary was held on Dec. 15 at the home of Mrs. F. L. Moore. Preceding the festivities, a business meeting was held, with Mrs. Robert Fox, president, presiding. One of the group's projects was the sending of robes, aprons and facial tissues to the detention home. Hose sold to auxiliary members helped finance this project.

After the business session, cards were played and later in the evening lunch was served. There was also a gift exchange. Committee in charge of arrangements included Mrs. M. M. Riddell, chairman, Mrs. C. I. Kuntz and Mrs. M. S. Huber.

SCIOTO

The Scioto County Auxiliary had the privilege, on Dec. 1, of presenting the entertainment feature at the annual Christmas dinner and meeting of the Hempstead Academy of Medicine. Produced and acted by auxiliary members, a "Cavalcade of the Past" was presented in twelve scenes, depicting actual activities of the local auxiliary during its nine and a half years of existence.

The regular meeting of the auxiliary was held on Dec. 14 at the home of Mrs. Clyde M. Fitch who, each year, plays hostess to the Christmas party. Unusual and striking Christmas decorations provided the background for the afternoon's festivities. The business meeting, under the direction of Mrs. W. A. Ray, president, preceded the passing party and special program. Christmas "treats" for the County Home were voted, as was a special appropriation to purchase needed replacements for the recreation room at the Home, an original project of the auxiliary. The feature of the afternoon was the showing by Mrs. Ralph Lewis of special motion pictures, in color, of Philippine Island activities taken by Dr. Lewis when he was stationed there. One such activity—the planting and harvesting of the rice—was presented in amazing detail and against a background of warmth, color and dramatic effect.

TRUMBULL

The Auxiliary to the Trumbull County Medical Society met for its annual Christmas party on Dec. 16 at the Trumbull Country Club. Following the luncheon, the business session was conducted by the president, Mrs. D. R. Mathie,

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when plans were discussed for a new money-making project in the form of a "Gardenia Ball." The money is to be used for the Nurse's Scholarship Fund.

Gifts were brought by each member, to be later distributed to the women of the County Home and to the children of the Christmas Stocking Club of the Salvation Army. At the completion of the business meeting, the Student Nurses' Chorus of the Trumbull Memorial Hospital presented a delightful program of Christmas music. Mrs. Kyle, program chairman, introduced the group.

A. M. A. Authorizes Study Of Physicians' Incomes

The A. M. A. Board of Trustees, meeting in Chicago Nov. 5, authorized the Bureau of Medical Economic Research to undertake a study of physicians' incomes during 1949. The study will be undertaken in cooperation with the Office of Business Economics of the U. S. Department of Commerce and will begin sometime next spring.

The Bar and Dental Associations previously have cooperated with the Department of Commerce in surveys of their respective professions.

The sample study will be of the mail-questionnaire type and will be prepared jointly by the Bureau of Medical Economic Research and the Department of Commerce. The sample will be drawn from the Bureau's complete punch-card file of physicians. The questionnaires will be confined principally to questions of income and those necessary to cross-classify the respondents. The physician will not sign his questionnaire.

COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Cleveland, May 16-18.

American Medical Association, Annual Session, San Francisco, June 26-30.

American Academy of General Practice, St. Louis, Feb. 20-23.

American Association of Industrial Physicians and Surgeons, 35th Annual Meeting, Sherman Hotel, Chicago, April 22-29.

American Association for Thoracic Surgery, Denver, Colo., April 15-19.

American College of Physicians, Boston, April 17-21.

American College of Radiology, San Francisco, Calif., June 25.

American Goiter Association, Shamrock Hotel, Houston, Texas, March 9-11.

American Pediatric Society, French Lick, Ind., May 8-10.

National Conference on Rural Health, Kansas City, Mo., Feb. 3-4.

National Tuberculosis Association, Washington, D. C., April 25-28.

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Observations Are Drawn From Cleveland X-Ray Survey

Greater Cleveland's X-Ray Survey which ran from March 5 through August 21 showed some results which are of interest to all Ohio doctors.

According to a report in *Ohio Public Health*, in that period of time 688,204 70mm. films were taken—684,763 by the survey team and the remainder by cooperating agencies.

Of the total number, 95.9 per cent were read as normal; 02.5 per cent were read as showing evidence of abnormality. Of the total number, 0.3 of one per cent showed definite evidence of tuberculosis, and one per cent showed evidence of suspected tuberculosis.

There were 0.5 of one per cent of the films which showed evidence of the presence of pathological change other than tuberculosis and heart disease. Conditions found included carcinoma, acute pneumonia, chronic suppurative lung disease, pneumonoconiosis, bronchiectasis, emphysema, mediastinal tumors, sarcoidosis, and diaphragmatic hernia. Of the total number, 0.7 of one per cent showed evidence of heart disease.

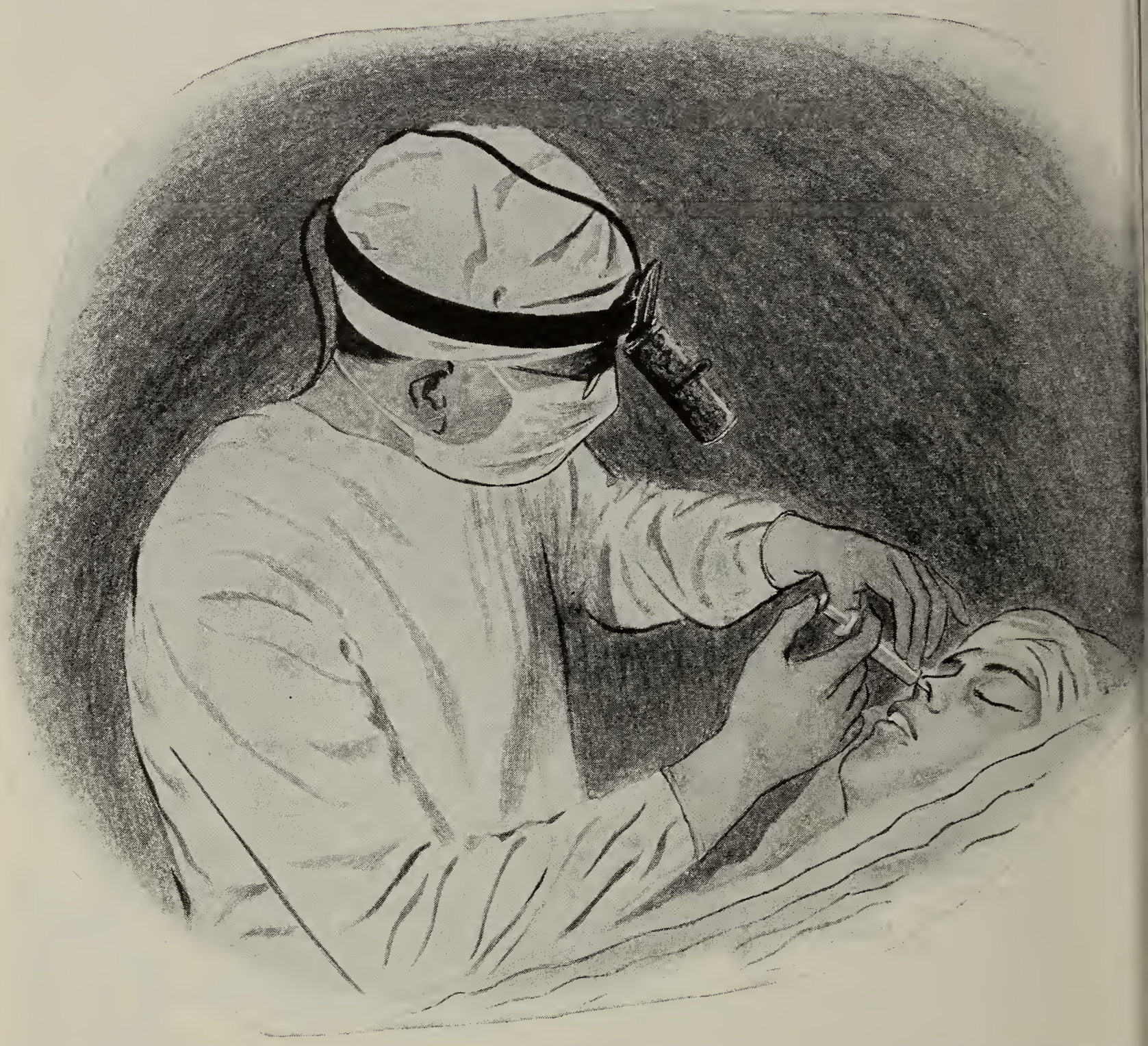
The percentages given show only evidence of disease following examination of the small film. Final figures following complete clinical investigation will not be available for some time.

At the time figures were compiled, 72.8 per cent of persons recalled for further clinical investigation had returned to the retake center. Officials estimate that this percentage will increase to 80.

Of the tuberculosis cases discovered, 64.6 per cent were in the minimal stage, 33.3 per cent were in the moderately advanced stage and only 02.1 per cent were in the far advanced stage.



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* Hamblen, E. C.: Some Aspects of Sex Endocrinology in General Practice, North Carolina M. J. 7:533 (Oct.) 1946.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Human Breeding and Survival: Population Roads to Peace and War, by Guy Irving Burch and Elmer Pendell (35 cents. *Penquin Books, Inc., New York City)*, has been well received in both its previous editions, and makes as strong a case for population limitation as can be made. There are many misunderstandings about this problem and many approaches. Even the strongest opponents of the use of contraceptives have written: "Catholic teaching, if loyally adopted, cannot possibly lead to an excessive and haphazard population." There is then no controversy on that score. The question is, shall we accept defeat or shall we spend our energies raising more and better food to supply our people and then spend some time giving a thing they have never been offered—an education for living within the biologic norm?

Rational Medicine, by John W. Todd ($6.50. *Williams & Wilkins Company, Baltmore, Maryland)*, lives up to its title. I have often recommended a book as "a must" for every physician, but never as wholeheartedly as I do this. It puts first things first. It shows what is rational and what is not about the practice of medicine —diagnosis, analysis of symptoms, physical signs, assessing the value of treatment, diet drugs, the role of food injection, psychotherapy, and the prevention of disease. Then, there is that brilliant chapter of 27 pages giving the biography of the child of an inadequate mother from conception to old age, showing how badly we all handle the constitutionally and nutritionally inadequate person.—"The Black Chapter of Medicine." By all means, get this book and read it for your own soul's sake and the good of your patients.

Gynecology and Gynecologic Nursing, by Norman F. Miller, M. D., and Betty Hyde, R. N., ($4.25. Second Edition. *W. B. Saunders Company, Philadelphia)* presents the necessary facts of nursing in this field as presented by the staff at The University of Michigan Medical School. Dr. Miller has done a good job of making clearer and more understandable the disease being cared for.

Nutrition of the Dog, by Clive M. McCay ($3.50. *Comstock Publishing Co., Inc., Ithaca, New York).* Most physicians are dog lovers and most of us own one or more. Most dogs grow old and die before their time because of poor eating habits. Few dog owners understand how to feed their dogs to insure health, a good nature, and a long life. Here is all of the known facts assembled by one of the outstanding nutritionists and a most successful practical dog feeder—Professor of Nutrition, Department of Animal Husbandry in the Cornell University.

Community Health, by Laurence B. Chenoweth, M. D., and Whitelaw R. Morrison, M. D., ($3.00. Third Edition. *Appleton-Century-Crofts, Inc., New York City)*, has been written by these two Ohio physicians as a college text on the subject. It has been written with an eye to giving the student a grasp not only of the subject but also of the cultural side—the historical developments upon which progress rests—so often missing even in our instruction in medical schools.

The Best Medicine, by Frederic M. Loomis, M. D., ($2.75. *Loomis Book Company, 516 Park Way, Piedmont, California)*, is a nicely printed gift edition of a series of short stories that have appeared in national magazines in recent years, by the author of "The Consultation Room," "The Bond Between Us," and "In a Chinese Garden." A wise physician and an experienced counselor, his stories are interesting and truly human.

Health Instruction Yearbook, 1949, compiled by Oliver E. Byrd, M. D., ($3.50. *Stanford University Press, Stanford, California)*, is the seventh annual appearance of this valuable resumé of 255 articles chosen from 1,643 read by the compiler. Your reviewer has come to look forward to the appearance of this annual as a check upon his own reading. It is one of the most valuable surveys of American medical and health literature that exists.

Ecology of Health, edited by E. H. L. Corwin, Ph. D., ($2.50. *The Commonwealth Fund, New York City)*, is the distillate of the papers read, and the discussions of them, at the 1947 Institute on Public Health sponsored by the New York Academy of Medicine: Genetics; Maternal Health; Animal and Insect Reservoirs of Disease; Climate, Geography and Disease; Realities in Preventive Psychiatry; Trends in State and Local Health Services; Professional and Lay Education in Support of the Public Health; and finally Government and Public Health. Such are the titles, and the list of essayists and discussants is from the Blue Book. Your reviewer has been insisting at all times for the last ten years that both health and disease must be approached and considered from the ecologic point of view. Here is the beginning.

Nutrition—A Survey of the Basic Cause of Disease, by Charles Noyes Kinney, Emeritus Professor of Chemistry, Drake University ($3.50. *Wallace-Homestead Company, Des Moines, Iowa)*,

is an elementary treatise prepared for use in the livestock feed industry. It is a book that physicians should read because it defends in elemental terms the thesis that disease is produced by, or results following, abnormal metabolism of the cell and that good health in man and beast is an ideal state of bodily chemical balance. The primary cause of all disease is, therefore, malnutrition. As would be expected, the author, just as most physicians would do, favors mineral and vitamin supplemental feedings which in your reviewer's opinion is proper until the soil can be restored by deep-rooted crops, trash mulch and compost as well as complete mineral fertilizers.

Beauty After Forty, by Edyth Thornton McLeod ($3.95. *Ziff-Davis Publishing Company, New York City)*, presents in a hopeful way the means by which the woman passing forty can assert her right to life, love, and happiness. It is the kind of book which could prevent many a middle-aged separation and make the life of many a husband happy by getting his mate's mind off her expected troublesome menopause. It is a helpful volume in every aspect of aging.

Textbook of Physiology, by William D. Zoethout and W. W. Tuttle ($4.75. Tenth Edition. *C. V. Mosby Company, St. Louis, Missouri)*, has been revised extensively. Among the new topics are: Ferritin, sedimentation rates, globulins, isotopes, lobotomy, the functions of the hypothalamus, regulation of body temperature and water content, energy balance and sleep.

Backgrounds of Social Medicine, by a group of authorities at a round-table conference held by The Milbank Memorial Fund (1.00 paper. *The Milbank Memorial Fund, New York City)*, is an attempt to get sickness on the basis of human ecology where it belongs. It is not Marxian to insist that environmental factors are of major importance in the production of sickness and that medicines must always play a role of minor significance even when in a crisis they may save a life for the time being. When our medical schools get chairs of social pathology devoted to the environmental factors in diseases, then the physician will lose his cast and priestly character and will be in danger of becoming merely a technician. Such an understanding of life at the same time will jeopardize the priesthood as well. It is a field, therefore, that every thinking physician should be exploring.

Relation of Soil Content to Human Longevity *(Apply T. J. Brooks, Assistant Commissioner of Agriculture of Florida, Tallahassee, Florida)*, is a report of the discussion of many scientists from many fields—a sort of scrapbook gathered together in an effective way by the former professor of economics in Mississippi State College and his son, chief physician of the Florida State University at Tallahassee. It supports in the main the contention which I have been defending throughout this country that there is a relation and a direct one between balanced soils, balanced foods, and robust health.

Operations of General Surgery, by Thomas G. Orr, M. D., ($13.50. Second Edition. *W. B. Saunders Company, Philadelphia)*, has been issued in its second edition within five years which speaks well for a text in this field. While the arrangement remains the same a considerable number of new techniques have been added. Seventeen hundred step-by-step illustrations serve to clarify adequate and clear descriptions of operations.

The Salt-Free Diet Cook Book, by Emil G. Conason and Ella Metz ($3.00. *Lear Publishers, New York City)*. As more and more physicians come to recognize the value of a salt-free diet in some 13 or more clinical conditions, the problem making such diets appetizing becomes of increasing importance for this is the only way to encourage fidelity. Here we have a cook book that tells us just how to do it. Fifty menus with receipes are presented as are suggestions for those who eat out and those who are diabetic.

Diagnosis of Syphilis by the General Practitioner, by Joseph Earle Moore (25 cents. *Superintendent of Public Documents, United States Printing Office, Washington, D. C.)*, is the simple statement of current information by the distinguished teacher at Johns Hopkins written for the U. S. Public Health Service.

Nutrition, by Margaret Chaney and Margaret Ahlborn ($3.90. Fourth Edition. *Houghton Mifflin Company, Boston, Massachusetts)*, is an excellent text for the alert teacher of this most important of all subjects.

Physiology of Heat Regulation and the Science of Clothing, by L. H. Newburgh, M. D., ($7.50. *W. B. Saunders Company, Philadelphia)*, is one of those books that grew out of the wartime activities of the National Research Council which can be used so profitably by peoples who are not at war. The relation of clothing to the weather and to climate is a much more important topic than most of us physicians have any idea.

Gynecological Endocrine Disorders, by C. L. Buxton, M. D., and E. T. Engle, M. D., ($2.00. *C. C. Thomas, Springfield, Illinois)*, is another of these efficient volumes written for the internist. This boils down a great flood of books for you and me.

Physiology of the Nervous System, by James F. Fulton, M. D., ($10.00. Third Edition, Revised. *Oxford University Press, New York City)*, brings us up to date since the second edition appeared six years ago. It includes the more significant developments.



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The Ohio State Medical Journal

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Vol. 46 March, 1950 No. 3

JONATHAN FORMAN, M. D., *Editor*

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Asst. Managing Editor

The Effect of Vitamin B_{12} on the Hematologic and Neurologic Manifestations of Pernicious Anemia

JOHN F. MUELLER, M.D., THOMAS JARROLD, M.D., V. R. HAWKINS, R.N., and RICHARD W. VILTER, M.D.

FOR many years numerous investigators have attempted to obtain the active anti-pernicious anemia substance from liver by fractionization. It was not until early in 1948 that Rickes, Brink, Koniuszy, Wood and Folkers[1] announced the isolation of a crystalline substance containing cobalt with an as yet unpublished chemical formula which they named vitamin B_{12}. Ultimate isolation depended upon the selection of a suitable micro-organism, Lactobacillus lactis Dorner, which required it for growth. The discovery of this method of assay provided a means by which its concentration could be determined during the process of refining liver.

Randolph West[2] was the first to use vitamin B_{12} clinically. He administered the material to three patients with pernicious anemia and obtained very satisfactory reticulocyte and erythrocyte responses. Soon thereafter Berk, Denny-Brown, Finland and Castle[3] reported a case of pernicious anemia with postero-lateral column disease who was sensitive to various liver extracts and who responded promptly to vitamin B_{12}. There was no apparent sensitivity to this fraction of liver. The effectiveness of this new member of the B-complex in nutritional macrocytic anemia and sprue was demonstrated by Spies[4] and co-workers in Puerto Rico and Cuba.

Various investigators have studied the relationship of vitamin B_{12} to the classic extrinsic-intrinsic factor hypothesis of Castle's. Bethell, Meyers and Neligh[5] reported that the feces of patients with pernicious anemia contained more vitamin B_{12} than one would need to administer parenterally to relieve their disease. They postulated that these patients were unable to absorb or utilize this material due to the lack of "intrinsic factor" in the gastric juice. This theory was

From the Department of Internal Medicine, College of Medicine, University of Cincinnati, Cincinnati, Ohio. These studies were aided by grants from Merck and Co., Inc., and the Robert Gould Research Foundation.

The Authors

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● Miss Hawkins, Cincinnati, Ohio, is a graduate of University of Cincinnati College of Nursing and Health, 1940; member, Ohio State Nurse's Association; medical head nurse, Cincinnati General Hospital; and research asst. to Dr. Vilter.

● Dr. Vilter, Cincinnati, Ohio, is a graduate of Harvard Medical School, 1937; member, American Society for Clinical Research; fellow, American College of Physicians; attending physician, Dept. of Internal Medicine and chief clinician, medical clinic, Cincinnati General Hospital; assoc. prof. of medicine and asst. dean, College of Medicine, University of Cincinnati.

given further impetus by the work of Berk, Castle, Welsh, Heinle, Anker and Epstein[6] who showed that the hematopoietic activity of orally administered vitamin B_{12} in pernicious anemia is greatly potentiated by the simultaneous administration of normal human gastric juice, but that the parenteral route of administration is much more effective. It is suggested from this work that vitamin B_{12} is identical with the food (extrinsic) factor which in turn is closely related to, if not identical with, the antipernicious anemia principle of liver.

This report deals with observations on seven patients with pernicious anemia treated with vitamin B_{12} during the past year, and confirms the effectiveness of this agent in microgram doses for the relief of hematologic, neurologic and glossal abnormalities of pernicious anemia.

MATERIALS AND METHODS

Four patients (Case 1, 2, 3, and 4) were seen and treated at the Cincinnati General Hospital and subsequently followed in our outpatient department. The remaining three patients were treated at another hospital and follow-up was impossible. Patients 2, 6 and 7 were new cases who were admitted with severe macrocytic anemia, achylia gastrica and megaloblastic maturation arrest of the bone marrow. Cases 1 and 5 had been diagnosed as having pernicious anemia three and two years, respectively, before this admission but had received no treatment in the interim. In addition, Case 5 presented himself with unequivocal evidence of postero-lateral column disease of at least two years' duration. Patients 3 and 4 were being treated with folic acid for investigative purposes at the time they developed spinal cord degeneration.

The following laboratory examinations were performed on all patients on admission. Erythrocyte count, hemoglobin concentration, leucocyte count, platelet count, reticulocyte count, and cover slip preparations of the peripheral blood and bone marrow stained with Wright-Giemsa stain. Gastric analysis following histamine stimulation, serum bilirubin, serology, stool examination and urinalysis were done routinely.

Following therapy, reticulocyte counts were performed daily for at least ten days and erythrocyte and hemoglobin determinations were done three times per week for two weeks and weekly thereafter. Re-examination of a sample of bone marrow was always performed at varying times following vitamin B_{12} therapy.

The dosage schedule varied since one of our purposes was the determination of a minimum effective dose. Patients without neurologic disease were given four micrograms or multiples thereof in single doses. The total hematologic effect of each dose was observed before giving additional material. This method was followed until clinical remission occurred and the patient was discharged from the hospital. Thereafter the patients were maintained on three to five micrograms per week.

The patients with neurological manifestations of pernicious anemia were given four to five micrograms of vitamin B_{12} every other day until a satisfactory clinical response was attained. Thereafter they were maintained on ten to twenty micrograms per week depending on individual needs. All therapy was given intramuscularly.

RESULTS

The hematologic response to these extremely small doses of vitamin B_{12} was gratifying. Subjective improvement was obvious within forty-eight hours and glossitis and bilirubinemia disappeared rapidly. The reticulocyte response was exceedingly good in all cases except one (Case 6), where the laboratory result is in question. It is interesting to note that twelve micrograms, i.e., approximately one microgram per day for ten days, usually induced a maximal clinical response. In Case 6, however, sixteen micrograms induced at best a suboptimal response. This patient's anemia was complicated by the presence of tabes dorsalis and optic atrophy. Whether these complications interfered with the response of his bone marrow to vitamin B_{12} is conjectural. No other adequate explanation could be found. That vitamin B_{12} exerts its maturation effect rapidly on the bone marrow can be ascertained by referring to Table I which records the nucleated erythroid components of the bone marrow per 100 white blood cells in Case 2 on four successive days. Six micrograms of vitamin B_{12} were given on the day of the first aspiration, September 7, 1948.

TABLE I

Date	Sept. 7, '48	Sept. 8, '48	Sept. 9, '48	Sept. 10, '48
Megaloblasts	6.5	2	0	0
Early Erythroblasts	30.5	18.5	9.5	6.5
Late Erythroblasts	39.5	30.5	72.5	76.5
Normoblasts	74	88.5	321.5	647
Myeloid—Erythroid ratio	1:1.5	1:1.4	1:4	1:7

Numbers of nucleated erythroid cells per 100 white blood cells in the bone marrow on four successive days in a patient with pernicious anemia who received 6 gamma of vitamin B_{12} on the first day.

In patients with neurologic relapse five micrograms every other day produced rapid clinical response in all patients except one (Case 5). In the latter, spinal cord disease had been present for at least two years prior to therapy so that very little improvement could be expected. He felt much better and his gait was more steady

TABLE II

HEMATOLOGIC AND CLINICAL DATA ON PATIENTS WITH PERNICIOUS ANEMIA TREATED WITH VITAMIN B_{12}

Case	Previous Treatment	Blood Count Before Therapy	Vitamin B_{12} Dosage	Reticulocyte Peak	Clinical Status	Blood Count at Start of Maintenance Therapy	Maintenance Dosage of Vitamin B_{12}	Blood Count After 6 Months of Therapy
1. M.M.	None	RBC 1.49 Hgb. 5.5 MCV 114	4 micrograms I.M. 4 micrograms I.M. in 3 weeks 4 micrograms I.M. in 4 weeks total=12 micrograms	43.8% on the 7th day	Improvement marked and immediate	RBC 3.20 Hgb. 12.5 MCV 115	6 micrograms q. wk. x 2 mo. 3 micrograms q. wk.	RBC 4.81 Hgb. 15.0 MCV 95
2. F.M.	None	RBC 1.17 Hgb. 5.8 MCV 128	6 micrograms I.M. 6 micrograms I.M. in 3 weeks total=12 micrograms	33.4% on the 6th day	Improvement marked and immediate	RBC 4.13 Hgb. 12.7 MCV 101	5 micrograms q. wk.	RBC 4.50 Hgb. 14.4 MCV 95
3. R.P.[1]	Folic Acid 50 mg. q.d.	RBC 3.90 Hgb. 13 MCV 94	5 micrograms I.M. q.o.d. x 26 days 5 micrograms I.M. 2 x week total=95 micrograms	None	Improvement definite but gradual and slow	RBC 4.17 Hgb. 14.2 MCV 100	5 micrograms q. wk. 15 micrograms q. wk.	RBC 4.51 Hgb. 15.0 MCV 95
4. F.R.[1]	Folic Acid 50 mg. q.d.	RBC 3.76 Hgb. 13.0 MCV 101	5 micrograms I.M. q.o.d. total=60 micrograms	None	Improvement definite but gradual and slow	RBC 3.81 Hgb. 12.6 MCV 102	5 micrograms 2 x wk. 10 micrograms 2 x wk.	RBC 3.87 Hgb. 12.5 MCV 95
5. J.T.[1]	None	RBC 1.39 Hgb. 4.9 MCV 129	4 micrograms I.M. q.o.d. total=32 micrograms	25.6% on the 8th day	Anemia responded rapidly. Cord disease improved minimally and quite gradually.	RBC 3.42 Hgb. 10.2 MCV 114	2 micrograms q.o.d.	RBC 4.19 Hgb. 12.5
6. H. M.[2]	None	RBC 1.16 Hgb. 4.5 MCV 163	4 micrograms I.M. 4 micrograms I.M. in 2 weeks 8 micrograms I.M. in 6 weeks total=12 micrograms	?	Improvement was only fair; very slow	RBC 3.09 Hgb. 9.0	Refined liver extract 30 units q. wk.	
7. J.S.	None	RBC 1.96 Hgb. 6.0 MCV 106	8 micrograms I.M. 4 micrograms I.M. in 6 weeks total=12 micrograms	14.6% on the 8th day	Improvement marked and immediate	RBC 4.15 Hgb. 11.5	Refined liver extract 30 units q. wk.	

1. With combined systems disease.
2. Central nervous system syphilis with optic atrophy.

after therapy, although the neurologic abnormalities were unchanged.

It was soon discovered that five micrograms weekly would not maintain neurologic improvement and larger doses in the range of ten micrograms twice a week were necessary. As would be expected from previous experiences with liver extract, patients with both hematologic and neurologic relapse required more than the twelve micrograms of vitamin B_{12} to induce a clinical remission.

CASE PROTOCOLS

Case 1: M.M., a 65-year-old white widow, was admitted to the Cincinnati General Hosptial on May 6, 1948, complaining of progressive weakness of two months' duration, dyspnea on exertion, easy fatigability, sore tongue and anorexia. Past history revealed that in 1945 the patient had been treated in a local hospital for pernicious anemia with refined liver extract. She was said to have received a suboptimal response from this therapy. There had been no intervening therapy.

Physical examination revealed a chronically ill, mildly malnourished white woman in no acute distress. The sclerae were mildly icteric. An old hemorrhage was noted in the fundus of the right eye. The tongue was smooth, glistening and pale. The lungs, heart and abdomen were entirely normal, except for a palpable non-tender liver 1½ cm. below the right costal margin. Neurological examination was normal.

Laboratory examinations revealed: Erythrocyte count, 1.490,000 per c. mm., hemoglobin 6.3 Gms. per cent, hematocrit 17 per cent, M.C.V. 114 cubic micrograms, M.C.H. 37 micromicrograms, M.C.H.C. 32 per cent, white blood count 2700 per c. mm., reticulocytes 4.6 per cent. Anisocytosis, poikilocytosis and hypersegmented polymorphonuclear leucocytes were noted in the peripheral blood. The Wassermann reaction was negative. Gastric analysis revealed histamine-fast achlorhydria. Maturation arrest at the megaloblastic stages of erythrocyte development was found in the bone marrow. Serum bilirubin totaled 2 mgs. per cent with 1.6 mg. per cent of the indirect reacting type. An upper gastroenteric roentgenologic examination with barium was normal.

On May 8, 1948, four micrograms of vitamin B_{12} were administered intramuscularly. In three days a repeat bone marrow aspiration revealed complete reversion to the normoblastic level. On the seventh day reticulocytosis reached a peak of 43.8 per cent. Clinical improvement was striking. By May 18, papillae could be seen on the lateral margins of the tongue, and the appetite had returned. The erythrocyte count rose to 2,200,000 per c. mm. and the hemoglobin to 8 gms. per cent. A second dose of four micrograms of vitamin B_{12} on May 26, 1948, produced a reticulocytosis of 14.3 per cent. The erythrocytes increased to 2,840,000 per c. mm. A third dose of four micrograms was given on June 19, 1948, with a subsequent reticulocytosis of 3.8 per cent and a rise in erythrocytes to 3,230,000 per c. mm. and hemoglobin to 11.8 per cent. At this point she was discharged from the hospital and has been followed in our clinic on 3 to 6 micrograms of vitamin B_{12} every week. Her blood counts rose to, and have been maintained at, normal levels.

Case 3: R.P., a 73-year-old unmarried white woman, was admitted to the Cincinnati General Hospital on November 2, 1948, complaining of numbness of the hands and inability to walk. Pernicious anemia was diagnosed in 1939 at which time she was treated with refined liver extract. In 1945 she was given folic acid, 30 mgs. three times a week, orally, because she refused further injections. In June, 1948, she experienced a hematological relapse, her erythrocyte count dropping from 4,480,000 per c. mm. to 2,490,000 per c. mm. On folic acid, 50 mgs. per day by mouth, the blood count rose to 4,650,000 per c. mm. in September, 1948. No neurologic manifestations were ever present. Six weeks before entry the patient accidentally fell and sustained a minor contusion of the right knee. Soon thereafter she began to complain of increasing weakness, numbness in the hands and feet, drawing sensation in the flanks and anorexia. The day before admission she was unable to walk due to extreme ataxia. She was admitted to the hospital.

Positive physical findings were limited to the nervous system. The cranial nerves were intact except for partial 8th N. deafness bilaterally. There was general, non-specific, weakness of all muscle groups. There was definite ataxia in the heel to shin test. Gait was wide-based and staggering. The Romberg test was positive. There was slight hypesthesia of the hands and feet. Perception of vibration was absent over the lower extremities up to about L 2-3 and over the finger tips. The sense of position in the toes was slightly impaired. The deep tendon reflexes were active and equal. The Chaddock response was abnormal bilaterally.

Laboratory determinations revealed: Erythrocytes 4,120,000 per c. mm., hemoglobin 13.8 Gms. per cent, hematocrit 39 per cent, M.C.V. 94 cubic micrograms, M.C.H. 33 micromicrograms, M.C.H.C. 35 per cent, white blood count 4200 per c. mm. Other laboratory findings were not pertinent.

The patient was given five micrograms of vitamin B_{12} every other day for four weeks. Within the first week there was mild subjective improvement. By the ninth day, vibration was perceived in the fingers for the first time. The Romberg test, although still positive, was improved. The patient stated that she had much more feeling in her hands. By the end of the second week she was able to walk by herself. The drawing in her hands was less annoying. Her strength had improved. Neurological examination at the end of four weeks revealed vibratory perception 20 per cent of normal in the fingers, 30 to 40 per cent over the sacrum, and absent in the lower extremities. The reflexes were unchanged. The Romberg sign was normal. The patient was able to walk up and down stairs. She was discharged from the hospital after four weeks of therapy.

The dose of vitamin B_{12} was changed to five micrograms twice a week. Further improvement did not occur. Recently we have increased the dose to fifteen micrograms each week and have noted very slow improvement.

DISCUSSION

In our brief experience, vitamin B_{12} has been as effective as liver extract in the treatment of pernicious anemia in relapse. Complete remission has been induced in the blood, bone marrow and

neurologic system. Glossitis and bilirubinemia have disappeared. There is absolutely no evidence from our experience or that of others that vitamin B_{12} is more effective than liver or will induce a response qualitatively or quantitatively different from liver. There is no evidence that it will be effective where liver extract is not. In our experience liver extract refractory megaloblastic anemia and the anemia of cirrhosis are unaffected, and in the experience of others, the same is true of leukemia and any other type of liver refractory anemia. The one real indication for vitamin B_{12} occurs in the patient with pernicious anemia who is sensitive to liver extract.

The effective dose is extremely small. On the average a total of twelve micrograms will produce a maximal hematologic response. Such data indicate that this compound is one of the most potent in medicine. The fact that the dose is so small suggests that vitamin B_{12} acts as an enzyme or catalyst in its role as a hematinic principle.

It should be emphasized, as we stated previously, that minimum doses were utilized in this study and it should not be assumed that these are the optimum doses. In a larger series of cases it would not be surprising if a certain number would not respond to these minimal amounts. We suggest for the routine treatment of pernicious anemia the dosage schedule of five micrograms of vitamin$_{12}$ each day for ten days and five micrograms each week thereafter until normal hematological values are reached. Further experience will be necessary to determine the requirements for long term therapy. For patients with neurologic manifestations of pernicious anemia a dose of ten micrograms per day is indicated and should be continued if necessary for two to six months until clinical remission is achieved and no further improvement occurs. Thereafter ten micrograms per week should be satisfactory, although individual variation may necessitate larger amounts.

It remains to be seen whether vitamin B_{12} will be as effective as liver extract over a period of years, but it is recommended for persons with pernicious anemia who are sensitive to liver and may even replace liver entirely if in the future it can be produced inexpensively.

SUMMARY AND CONCLUSIONS

1. Vitamin B_{12} is effective in the treatment of the hematologic, neurologic and glossal manifestations of pernicious anemia.

2. One microgram of vitamin B_{12} is roughly equivalent to one U.S.P. unit of liver extract and twelve micrograms usually induces a satisfactory hematologic remission. Five micrograms every other day induces a satisfactory clinical response in patients with combined system disease.

3. For routine treatment of pernicious anemia we recommend five micrograms of vitamin B_{12} each day for ten days and five micrograms every week thereafter. At least 10 micrograms daily for several months will be required if neurological abnormalities are found.

4. There is no evidence that vitamin B_{12} has any more to offer a patient with pernicious anemia than liver extract. At present, liver extract sensitivity is the one definite indication for vitamin B_{12} therapy in pernicious anemia.

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Streptomycin in Treatment of Progressive Primary Tuberculous Lesions

The results of streptomycin treatment in progressive primary tuberclosis may be summarized as follows:

1. It uniformly lessened and in most cases obliterated the toxic manifestations in 25 patients treated. The improvement usually became apparent within a few days after the treatment was begun.

2. It reversed the general downward clinical course of the disease.

3. The physical findings improved and were clearly demonstrable in 30 to 60 days after treatment was begun.

4. The decreased roentgenologic findings followed the improvement in the clinical picture.

5. Sputum conversion was completed in four to five months in 89 per cent of progressive primary lesions.

6. The hospital stay was uniformly reduced roughly from two to three weeks to six to eight months' time.

In spite of the fact, however, that streptomycin has shown great promise especially in Progressive Primary Tuberculosis in children it should not be considered a cure-all; its use is still in the experimental stage and larger numbers will have to be observed over a longer period of time before an exact and complete evaluation of its worth in this field can be given.—McEnery, Sweany, Turner, Chicago; Ill. Med. Jour., Vol. 97, No. 1, January, 1950.

Causes of Failures in Patients in Whom Resuscitation Was Attempted*

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SOME of the physiological aspects of acute cardiorespiratory failure have been discussed in the preceding papers. It is the purpose of this paper to consider the problems associated with the application of this information to the surgical patient. Ideally it would be better to prevent acute cardiorespiratory failure in the operating room, and wise management will undoubtedly prevent many of these catastrophies; but it also seems fairly evident that in spite of good management, and until our knowledge has been extended, there will continue to be cases of sudden unexpected death.

We can be pessimistic and accept these as inevitable fatalities and hope that we as individuals do not have many such experiences in a lifetime, or we can accept the challenge of the problem and make a maximal effort to use all available physiologic knowledge in an attempt to resuscitate those cases in which physiologic death is in the process of stealing our patient.

WHY A RARE EVENT?

Although successful resuscitations have been reported both from cardiac standstill and ventricular fibrillation, the recoveries represent only a very small fraction of all of the patients who develop these difficulties. Why, then, is successful resuscitation such a rare event? In an attempt to get at least a partial answer to this question we have reviewed a group of patients in whom resuscitation from acute circulatory failure was attempted by exposing the heart and trying to restore a coordinated heart beat and reestablish the circulation of the blood.

In the past two years it has been our aim to attempt resuscitation by direct exposure of the heart whenever acute cardiorespiratory failure has developed in an operating room. We think that every surgeon, regardless of his specialization, who is in command of an operating room must be prepared to make important decisions swiftly and at least to institute the early steps of resuscitation so as to restore the flow of oxygen to the brain, which is the all-important consideration in successful resuscitation.

There have been ten attempted resuscitations in the study group, only one being completely successful. The others showed varying degrees of recovery, but had irreparable cerebral damage due to anoxia and eventually succumbed. A few of these cases will be reviewed in some detail, since they point out various obstacles to successful resuscitation.

FIRST CASE

The first case to be reviewed is that of a well-developed and well-nourished 16-year-old white girl with a chronic mastoid infection and cholesteatoma. She was taken to the ENT operating room. The posterior auricular region was infiltrated with 20 cc. of 1 per cent procaine solution with 8 drops to the ounce of 1-1000 adrenalin. She had received morphine sulphate gr. 1/6 Atropine gr. 1/150 as premedication. Her blood pressure rose from 100/70 to 170/50 after the procaine injection, and she complained of a violent headache, retched, vomited, and had a generalized convulsion. Following this, the pulse and blood pressure could not be obtained. A tracheal tube was immediately inserted by the anesthetist and an attempt made to massage the heart by pressing against the epigastrium. Intracardiac adrenalin was given. There was no apparent response to either of these measures.

Within five minutes time a surgeon was called, the chest exposed and opened through an intercostal incision. Ventricular fibrillation was seen to be present. Cardiac massage was begun and maintained for 20 minutes before a spontaneous coordinated beat was obtained by electrical shock-

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ing. During the period of massage an adequate cerebral circulation was maintained as evidenced by the fact that spontaneous respiratory effort was resumed after four to five minutes of direct cardiac massage. The patient recovered a normal pulse and respirations but died twenty-four hours later with convulsions and hyperpyrexia without regaining consciousness.

This patient might possibly have been successfully resuscitated if all the factors delaying the opening of the chest had been eliminated. Once the chest is opened and the circulation is being maintained by cardiac massage, loss of time is not so serious a factor as before, but every effort must be made to eliminate all delays in the procedure.

SECOND CASE

The second case is that of a 56-year-old man having bronchograms done in the X-ray department, on the second floor of the hospital. The patient's throat was cocainized with the usual dose of cocain. After 20 minutes, topical anesthesia was not entirely satisfactory, and a second application of cocaine was made into the trachea. The total dose used was considered within the limits of safety. However, the patient immediately became unconscious and stopped breathing. In the X-ray department there were no facilities available for resuscitation other than prone pressure artificial respiration. The anesthesia department was called and, in an estimated six minutes, brought gas machine, tracheal intubation equipment to the floor, but then it was decided to take the patient to the operating room, and another 6 to 10 minutes were consumed getting the patient into an operating room and getting a thoracic surgeon to open the chest and start cardiac massage.

The heart, which was in a state of cardiac arrest, was readily started by gentle massage. The patient rapidly developed a palpable pulse, measurable blood pressure, showed signs of returning peripheral circulation, and began in a short time to show spontaneous respiratory activity. Within an hour he showed generalized muscular twitching which progressed into violent generalized convulsions. He died with hyperpyrexia in about twenty-four hours. Could direct resuscitative measures have been instituted immediately when the heart stopped there would have been a better chance of success in this case.

Another cause of failure of the resuscitation procedure is cumulative biochemical disturbances that accompany a prolonged period of respiratory insufficiency. This is most frequently seen in long transpleural operations. When the breathing mechanism of a patient is for any reason impaired during operation, it is the custom for the anesthetist to administer higher oxygen concentrations to prevent anoxia. A patient's skin color can be maintained fairly normal by such a method although more precise methods of study may show varying degrees of hypoxia. The carbon dioxide exchange during such a time is apt to be forgotten. The only way for carbon dioxide to obtain exit from the body is to accumulate until the diffusion partial pressure is sufficient to permit the carbon dioxide to again flow from the body. If such a condition persists for a considerable time, a serious acidosis may develop. This is believed to precede the sudden circulatory collapse which comes without warning to some of these patients.

EXAMPLE OF TYPE

The next case is probably an example of this type of disturbance.

A 15-year-old girl was subjected to a left lower lobe lobectomy and lingulectomy for severe bronchiectasis of long standing. The dissection was moderately difficult due to lymph nodes and fibrosis around the hilus of the lobe, but everything seemed to progress satisfactorily, and blood loss was replaced by continuous transfusion during the procedure. The procedure was carried out without incident to the completion of the closure of the chest wall and skin. When the patient was turned from the side to her back and the anesthesia was being discontinued, the patient suddenly became pulseless. There had been no anesthetic agent administered for 30 minutes. The wound was rapidly opened and the heart found in standstill. Heart beat was restored by the use of massage, adrenalin, and calcium chloride. The patient maintained a circulation which was poor in quality and did not improve. She did not regain consciousness and died twelve hours later.

It is extremely difficult in transpleural operations to maintain pulmonary ventilation exactly at a normal level. It is our belief that this can only be done in long operations by controlled breathing—either by intermittent compression of the breathing with the hand or by a mechanical method such as is discussed elsewhere in these papers. This introduces new problems into the management of the anesthesia which time does not permit us to outline at present, but augmented and controlled breathing is finding wide application in thoracic surgery. It is doubtful whether there is much indication for this in non-thoracic surgery since the breathing mechanism is exceedingly dependable when we do not place too much of a burden on it in the way of heavy premedications and depressing doses of anesthetic agents.

AFFECTS OF ANOXIA

The affects of anoxia must not be ignored. We must remember that when the skin is

cyanotic the myocardium, too, is cyanotic. Anoxia is most easily not recognized in colored patients and in anemic patients. The following is an example:

A 20-year-old Negro male had an extrapleural exploration of the posterior mediastinum through a posterior rib resection for a mediastinal abscess. His induction was uneventful, but he developed cyanosis as the procedure progressed and suddenly his pulse and pressure became imperceptible. Intratracheal tube was in place so there was no interruption of the oxygen supply to the lungs. Time was taken to pack the posterior wound closed, and the patient was turned and an anterior incision made and the heart massaged. The elapsed time from the stoppage to restoration of circulation by massage was four or five minutes, and there was return to normal spontaneous respirations in thirty minutes. He too never regained consciousness and soon began to have muscular twitching. He developed hyperthermia and died within twenty-four hours. The question as to the presence of mediastinal reflexes in this man was brought up but more or less discarded in favor of the presumed cumulative effects of severe anoxemia. This has been well demonstrated lately by the studies made with continuous photo-electric estimations of the hemoglobin saturation with oxygen done by Hartman and McClure, who have shown that rather marked deficits may exist even in the presence of normal gross appearance of the patients. That this effect limits the patient's ability to tolerate complete anoxemia to the brain cannot be doubted. Again in this case some time was lost on the part of the surgeon to at least superficially close his operative wound. This could have been better done after the beat of the heart had been restored.

Another example of this same phenomenon was one of the saddest cases that we have had. A 33-year-old colored man who was an excellent physical specimen and in whom we had an interest because he had had a gastrectomy for peptic ulcer some years before, was given a gas-oxygen-ether anesthetic for an appendectomy for acute appendicitis. Induction was stormy, and as so often the case in a large muscular individual, there was much retching and vomiting. The trachea was aspirated, the anesthetic discontinued, and 100 per cent oxygen given. The heart and respirations ceased. An intratracheal tube was passed, intracardiac adrenalin given, and the heart exposed. It was in standstill. Procaine was given intracardially, and the heart started off with a normal mechanism soon after massage was instituted. Spontaneous respirations appeared in forty minutes, but the patient again developed convulsions and hyperpyrexia and died in five hours. Again the factors that defeated the surgeon were the time used in making the diagnosis and entering the chest, and the probable factor of preceding cyanosis limiting the ability of the brain cells to tolerate anoxemia.

Pre-existing shock is another factor that seems to limit the ability of the patient to recuperate from cardiac arrest, although in these instances perhaps the cardiac arrest is only a part of the mechanism of death in shock, and restoration of the heart beat merely delays death.

SHOCK CASES

We have had two cases in which shock seemed to be the factor that precipitated cardiac standstill.

First, a 32-year-old colored male was stabbed in the abdomen, and the knife blade broke off in the abdomen. He was brought to the hospital with no pulse nor blood pressure. Blood pressure was restored rapidly to 150/50 with the use of intra-arterial transfusion, and he was explored. The bleeding was coming through the pancreas, and this area was sutured. This done, the patient's bleeding stopped and all seemed well until the anesthetist said that the patient had no pulse; we realized that the bleeding stopped because of circulatory failure. The chest was opened, and the heart started readily, but it was about eight minutes from the time that the surgeon noted that the abdominal bleeding had stopped before a noticeable circulation was obtained. The patient lived three hours, did not develop convulsions, but remained in shock, i. e., blood pressure remained below 80/60. At autopsy there were holes in the abdominal aorta and the celiac axis. We perhaps had underestimated the degree of this patient's shock and had not treated it extensively enough, which may be something to think about in the use of interarterial transfusion where the peripheral blood pressure is so readily restored.

Another example of this same type of problem was a 46-year-old colored woman who had had numerous abdominal operations, the last, three months before admission, for intestinal obstruction. She was admitted on this occasion with a five-day history of intestinal obstruction. She was prepared by the usual methods, we thought adequately, and given 14 mg. of pontocaine intrathecally for an anesthetic. Her pulse and respirations ceased, and the heart was exposed and massaged immediately. It was in standstill and started with the first touch of the hand but recovered its vigor only after the patient was given adrenalin and neosynephrine to support the peripheral circulation. The patient gradually regained a better pulse and over a period of time the blood pressure was restored to normal. The respirations never returned to normal, and the patient began to have convulsions and died in six hours. Here the cause of death

was the period of anoxemia of the brain, but the mechanism was lack of circulation blood due to shock rather than anoxemia as in the previous cases, for the circulation was not interrupted for more than two or three minutes.

SUMMARY

The obstacles to better results in resuscitation procedures seem to be:

1. Inability to recognize the exact time of cessation of the circulation so that cardiac massage can be immediately instituted.

2. Delay in opening the chest and restoring the oxygenation of the brain by artificial pulmonary ventilation and cardiac massage.

3. Delay in getting necessary drugs and shocking device and other equipment necessary in restoring the circulation.

4. Pre-existing organic disease such as those involving heart, lungs, and brain.

5. The effects of anoxia, hypercapnia, and surgical shock.

Some of the conclusions and recommendations are obvious:

1. Better equipped and staffed operating rooms.

2. All procedures that might require resuscitative measures must be done where those measures are immediately available.

3. All surgeons must be prepared to carry out resuscitative procedures—including cardiac massage and defibrillation of the ventricles.

4. Great care must be exercised in not opening the chest unless there is complete circulatory arrest or the damage done might easily outweigh the benefits. Direct writing electrocardiogram in every operating room would be a great help in making such a decision.

5. Even if there are few successful resuscitations, a better understanding of the physiology involved will greatly aid in the prevention of these catastrophies.

The Human Dentition

Owing to the effects of civilization, the teeth of the higher classes of both the American and European peoples are often decayed, which is not so much the effect of a weakness of the structure of the teeth as it is the result of unnatural foods and habits.

The closer the human family approaches the natural methods of life and the teeth are made to perform their normal functions, the more often do we find a better structure and arrangement of the dental organs.—William F. Nelson, D. D. S., Wilmington, Del.; Delaware State Medical Journal, Volume 22, Number 1, January, 1950.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Gonorrhea—The name of this disease is derived from the Greek words, "gonos," meaning seed, and "rhoia," meaning flow. The term is actually a misnomer due to the fact that ancient physicians erroneously believed that the discharges of gonnorhea in the male were an involuntary loss or flow of semen or seed, instead of a discharge of pus. The origin of the term is usually attributed to Galen, who lived in the Third Century A. D., but some historians say the term goes back to Hippocrates or about 460 B. C.

Skeleton—Literally this word means a dried body or a mummy. It is derived from the Greek word, skello, meaning "I make dry." Originally, it meant the bones of any animal dried and retained in their natural position.

Testicle—Derived from the Latin word "testiculus" which is a diminutive of the Latin word "testis" meaning a witness and hence "testicle," a witness or proof of virility.

Gleet—This designation for the chronic stage of urethritis is descriptive of the muco—purulent discharge which is present. Gleet is derived from the old middle English word "glet," which in turn comes from the French term "glette," meaning the "froth of an egg." There is also the low German word "glett" meaning slippery.

Hymen—Hymen was the ancient Greek mythological God of marriage and nuptial song. He is remembered by us medically in the term we use to designate the delicate female membrane which is supposed to be ruptured on the wedding night.

Aphrodisiac—These sex-exciting drugs derive their name from the classical Greek mythology and are named in honor of Aphrodite the Greek Goddess of Love.

Epsom Salts—So called after Epsom Downs in Surrey, England, from whose waters it was originally obtained.

Piles—A term descriptive of the appearance of the lesion and derived from the Latin word "pila" meaning a ball or globe.

Privy—This essential structure of our rural civilization has many designations such as, outhouse, backhouse, Chick Sale, or necessary; but technically and most universally used is the term "privy." This term is derived from the French word "prive" or private which in turn comes from the Latin word privus meaning "ones own" or "assigned to private uses."

Catarrh—A name descriptive of the condition. It is derived from the Latin "catarrhus" which in turn stems from the Greek words "kata" or down and "rhea," I flow.

HARRY WAIN, M. D., Mansfield, Ohio.

Low Calcium and Mineral Oil Treatment of Poliomyelitis—Three-Year Report

BERT C. WILEY, M.D.

THIS method of treatment was developed by the Physical Medicine Department of the Miami Valley Hospital, Dayton, Ohio, near the end of the 1945 poliomyelitis season. It is based upon the theory that the poliomyelitis virus requires ionized calcium for its propagation, and that the virus or its toxin is distributed throughout the body as a fat-soluble material.[1, 2]

The chief change made in this treatment during the past two years has been the addition of Benadryl. It is given subcutaneously in 10 to 25 mg. amounts every 4 to 6 hours as needed to stop or prevent the formation of increased pharyngeal mucus. This routine has enabled us to keep the air-ways satisfactorily open. Aspiration has been needed only initially or when the dosage or timing of the drug were not properly adjusted. It has been the greatest single factor in reducing the morbidity and mortality of our bulbar cases.

The essentials of our mimeographed checklist of initial orders follow:

1. Low calcium, high carbohydrate, low vitamin D diet.
2. Only SOFT water urged: 1500 to 2500 cc per day.
3. Sodium acid phosphate gr 5 to 30, 3 times a day with meals.
4. Mineral oil 1/2 to 2 oz stat., then 1/2 to 1-1/2 oz at bedtime daily.
5. Prostigmine bromide 7-1/2 to 15 mg p. o. four times a day, 20 minutes before meals and at bedtime (for smooth muscle stimulation).
6. Phenobarbital gr 1/4 to 1/2 three times a day, and at bedtime as long as thought necessary.
7. Aspirin or APC q4h for pain or temperature of 100° or over, as long as thought necessary.
8. Cold wet packs for fever of 102° or over, as long as thought necessary.
9. SS enema stat., then q. o. d. as long as thought necessary.

Prostigmine Methyl Sulphate 1/2000 1 cc "H," 10 minutes before subsequent enemas if initial enema is not expelled well, as long as thought necessary.

10. If unable to void:
    a. Try hot water bottle to suprapubic region, as long as thought necessary.
    b. Catheterize q6h for three times, then
    c. Insert Foley, drain q4h, and irrigate with Aqueous Zephiran 1/20,000 q8h.
11. For increased pharyngeal mucus:
    a. High shock position (30°).
    b. Aspirate as long as thought necessary.
    c. Benadryl 15-25 mg "H" q6h.
12. Have respirator ready start with: 0-4 positive pressure; 10 to 15 negative suction; 20-26 R.

Submitted August 17, 1949.

The Author

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This private general hospital provided an excellent opportunity to compare the results obtained with this treatment and the results obtained with other currently good poliomyelitis management. Practically all cases not given the low calcium and mineral oil treatment were handled by well-qualified members of the Attending Staff of pediatricians, internists or orthopedists. The cases given "other treatment" are definitely not controls, since all other aspects of their management was not the same as that for the "treated" cases. They were merely not given the low calcium and mineral oil treatment, but were given what was considered good management. Yet they do serve as a valid gross basis for comparison. Those patients included in the "not possible" list arrived in too poor a condition to take anything orally, either voluntarily or by gavage, and so

Numbers Treated

Year	Low-Calcium Mineral Oil Treatment	Other Treatment	Treatment Not Possible
1946	41	4	2
1947	62	14	3
1948	36	7	2
	139	25	7

Complete Recovery

Year	Low Calcium Mineral Oil Treatment		Other Treatment		Treatment Not Possible
	No.	%	No.	%	
1946	26	61.8	1	25.0	0
1947	37	59.7	3	21.5	0
1948	18	50.0	1	14.3	0
	81	58.3	5	20.0	0

Complete Recovery or Insignificant Impairment

Year	Low Calcium Mineral Oil Treatment		Other Treatment		Treatment Not Possible
	No.	%	No.	%	
1946	33	78.6	2	50.0	0
1947	46	74.2	8	57.0	0
1948	24	66.7	3	42.9	0
	103	74.0	13	52.0	0

Deaths

Year	Low Calcium Mineral Oil Treatment		Other Treatment		Treatment Not Possible	
	No.	%	No.	%	No.	%
1946	0	----	0	0.0	2	100.0
1947	0	----	2	14.3	3	100.0
1948	0	----	0	0.0	2	100.0
	0	----	2	8.0	7	100.0

Days Onset to Walk

Year	Low Calcium Mineral Oil Treatment	Other Treatment	Treatment Not Possible
1946	25.6	39.3	----
1947	21.6	50.4	----
1948	18.9	44.1	----
	22.0	44.6	----

Days Duration of Follow-Up

Year	Low Calcium Mineral Oil Treatment	Other Treatment	Treatment Not Possible
1946	106.7	94.15	6.5
1947	113.4	58.6	6.0
1948	123.5	80.3	4.0
	114.5	77.7	5.5

form a definite limitation upon this treatment regime.

The preventive possibilities of this regime[3] apparently have never been significantly tried. At least no patients were admitted who had carried out the preventive recommendations.

SUMMARY

1. There were no deaths among any poliomyelitis patients who were admitted in time to try the low calcium and mineral oil treatment, and upon whom it was used.

2. When the results in 139 poliomyelitis patients who were given the low calcium and mineral oil treatment during the past three years, are compared with the results of 25 poliomyelitis patients admitted during the same period, to whom this treatment could have been given but electively was not, the following data are obtained:

a. There were nearly three times as many complete recoveries among the "treated" patients.

b. There were over 40 per cent more "treated" patients who achieved either complete recovery or functionally insignificant residual impairment than the "other treatment" patients.

c. On the average, the "treated" patients were able to walk in about one-half the time.

The chief factor in favor of further trial of the low calcium and mineral oil treatment is that it has resulted in apparent benefit to patients who otherwise could be offered little, in the light of our present knowledge of poliomyelitis.

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Care of the Newborn

The neonatal period still contributes over 60 per cent of deaths that occur during the first year of life—despite the fall in neonatal mortality from 31 to 21 per 1000 live births in the past 15 years.

Modern care of the newborn is concerned with attention to factors that may operate before and during birth as well as in the neonatal period. The health and nutrition of the mother from conception on may effect the embryo and fetus and be responsible for congenital malformations, abortions, stillbirths and premature births.

Modern obstetric management protects the infant from traumatic injury during delivery but the injurious effects of anoxemia, responsible for 58 per cent of liveborn infant deaths, are far from being controlled.

The major causes of disease in the newborn are anoxic injuries, traumatic injuries, infections, congenital defects and erythroblastosis. Some anoxic injury can be arrested or minimized through the prophylactic use of oxygen. When the anoxic injury is accompanied by generalized edema the administration of fluid is contraindicated. The mortality due to erythroblastosis fetalis has fallen as the result of early delivery in indicated cases with immediate replacement transfusion. Many congenital malformations; tracheo-esophageal fistulae; absence of the bile ducts; various type of intestinal obstruction; and diaphragmatic hernias now have an excellent chance of being cured by surgery if promptly diagnosed. There is good reason to believe that epidemic diarrhea of the newborn can be eliminated through improved nursery technique and the application of simple epidemologic principles.—S. H. Clifford, M. D., Boston; Jour. of Maine Med. Assn., Vol. 41, No. 1, Jan., 1950.

Unusual Fracture of Cervical Spine with Marie-Strumpell Disease

HARVEY R. HATHAWAY, M. D.

MR. F. C., a white male, 37 years old, was walking in shorts in his kitchen after a bath looking for an electric light cord. He fell on the floor on his right shoulder when he stumbled over a box in the dark. A flash of light was noted accompanied by a snap in his neck and pain. However, he arose and called on the telephone himself, reporting his experience, stating he had no paralysis, weakness or paresthesia, only discomfort in his neck. After resting in bed for two hours, he developed trouble in breathing, his lower jaw tending to protrude. When he voluntarily replaced his jaw, dyspnea occurred.

Past history of severe rheumatoid arthritis in 1933 with ankylosis of entire spine and sacroiliac joints. There was only 15 to 20° motion in his hip joints. He was struck by an auto in 1943 with a compression fracture of L 4 vertebra, making a good recovery.

Physical examination two hours after his present injury revealed no unusual respiratory difficulty, but he talked with a little dysphonia. Patient was lying on his left side with a rigid neck. Patient gagged easily, but nasopharynx appeared normal. Examination of entire body revealed no other abnormalities. There was no peripheral weakness nor abnormal reflexes of extremities. Blood pressure, 120/70; pulse 100.

After examination the patient developed difficulty in breathing and tried to raise up in bed. In one minute respiration was normal on lying down again. Arrangements were made to hospitalize the patient by ambulance. Approximately two hours forty-five minutes after his injury and before the ambulance arrived, the patient again developed dyspnea, asking for a hose from the enema bag. He developed cyanosis and died.

The patient was transported to Lakewood Hospital where postmortem examination revealed 35 to 40 cc of blood infiltrated into soft tissue of the prevertebral area extending from the third to fifth cervical vertebrae. There was narrowing of the hypopharynx just above the glottis, and slight edema of the mucuous membrane. Also, separation was described between the 4th and 5th cervical vertebrae with an irregular fracture line. The dura appeared intact. No subdural or subarachnoid hemorrhage was found in the brain. No free blood in the spinal canal. After fixation, microscopic examination of the midbrain, pons, medulla, cerebellum and upper cervical spinal cord revealed no gross lesions.

Final significant anatomical diagnoses:

1. Fracture of cervical vertebrae at junction of 4th and 5th.

2. Hemorrhage into adjacent paravertebral and prevertebral tissue with partial stenosis of the glottis. Slight edema of larynx. Marked rheumatoid arthritis of vertebral column. Passive hyperemia and focal hemorrhage in lungs.



FIGURE I

3. Slight generalized arteriosclerosis.

X-ray plates made postmortem exaggerate the deformity as shown in Figure 1.

I shall appreciate explanation of the cause of death of this patient.

Submitted July 14, 1949.

The Author

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The Sex Deviate

The drama of sex begins in childhood and many psychologic and biologic situations produce deviations in sex development. The basis for narcissistic displacements, for guilt feelings, and for defensive sadistic impulses can be laid bare to an adolescent so that he can adjust to and control his tendencies even if they cannot be eradicated. —E. E. Mayer, M. D., Pittsburgh; Penna. Med. Jour., Vol. 53, No. 1, January, 1950.

Sympathectomy and Phlebectomy for Post-Phlebitic Ulcer*

RICHARD HOTZ, M. D., and FRED M. DOUGLASS, Jr., M. D.

THE post-phlebitic ulcer is a chronic indurated indolent ulcer of the lower extremity following deep obstruction, usually, thrombophlebitis or phlebothrombosis, of the femoral system. It is characterized by chronicity, inflammation, local necrosis, peripheral and general saphenous varices, evidence of local phlebitis and edema, and most importantly by cold, wet feet.

The phlebitic or stasic ulcer is conceived in obstruction, maturated in stasis, born of trauma and infection, and perpetuated by local tissue anoxia. It is evident, therefore, that therapy directed toward the cure of the mature stasic ulcer must take into account all phases of its origin and development rather than the correction of but one or two of these.

It must be emphasized at the onset of this discussion that we are interested in a special form of ulcer to be differentiated from the simple varicose ulcer. The latter is shallow, relatively clean, with evident long saphenous insufficiency, and no evidence of deep obstruction. Until recently, various tests for the competency of the deep venous circulation had been considered mandatory before treating such varicose ulcers. Therefore, many patients with true post-phlebitic ulcer have been denied the elemental therapy of eliminating superficial stasis for fear of increasing leg edema.

The purpose of the combined operation is to eliminate both superficial and deep venous stasis, to remove large pools of stagnant blood about and beneath the ulcer, and to relieve the local tissue anoxia by increasing the arterial and arteriolar blood supply to the affected area.

The surgical management of varicose veins and their complications needs no documentation. Since Celsus first performed phlebotomy for thrombis, to this time, the surgical treatment of superficial varices has come through progressive stages until there is general recognition of the need for ligation of the tributary veins about the foramen ovale and the removal or destruction of the major superficial channels and their communicating veins.

The value of surgical therapy for deep phlebitis, whether acute or chronic, and for phlebothrombosis, has been less clear until recent years. Sporadic incidences of ligation of the external femoral vein appear in the literature but no concerted attack against thrombo-embolism by ligation was made until Homans[1] showed the safety of such a procedure. Repeated publications by Homans,[2] Ochsner,[3] et al., Allen[4] and associates, Linton[5] and many others have established the rationale and safety of femoral interruption in acute phlebitis. Its merits when contrasted to heparin and dicumarol therapy, so favored by Murray,[6] Bower,[7] and most recently Wise[8] and associates, is not statistically evident at this time and is not subject to discussion here.

Through the years ligation of the chronic femoral veins has been avoided though Homans suggested this as a rational and harmless operation in 1937. It remained for Buxton, Coller[9] and their associates to report their favorable experiences in ligating the external femoral for chronic phlebitis. They conclusively demonstrated that edema and ulceration were not increased by such ligation, but that stasic ulcers improved or healed without evidence of untoward sequelae in 24 consecutive cases. Soon Linton,[10] Himler[11] et al., Ochsner,[12] and others reported similar favorable results.

Simultaneous ligation of the saphenous system and of the external femoral vein was the logical conclusion of these clinical investigations. Linton and Hardy,[10,13] Vaughn,[14] Rees and Slavin[15] have shown enhanced venous return following combined operation with healing of stasic ulcers and a reduction in edema of the operated limbs in a majority of cases.

Ochsner and DeBakey[16] have long advocated paravertebral block of thrombotic extremities, after they noted that the associated angiospasm contributed much to the edema and pain of such limbs. They, Nicholson[17] and Niade,[18] have shown that remarkable relief of pain and edema follows this simple treatment. The fundamental re-

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* From the surgical service of F. M. Douglass Sr., and the Maumee Valley Hospital.

searches of Laufman[19] and associates has clearly shown the relationship between thrombosis and arterial spasm, so that anti-spasmodic therapy has been established in scientific evidence as well as in clinical experience. It remained for Shumacker and Abramson[20] to show the value of lumbar sympathectomy in chronic stasic ulcers following frostbite. The relief of local tissue anoxia by lumbar sympathectomy in the presence of ulcers has subsequently been advocated by the same authors,[21] by Krontiris,[22] Voris,[23] Lisker,[24] and several others. Patients who have a marked degree of arteriosclerosis were formerly thought to be beyond the aid of lumbar sympathectomy. Jemerin,[25] Trimbell,[26] et al., de Takats,[27] and associates, have shown that a large measure of relief from both pain and edema can be given these individuals despite the lack of confirmatory laboratory evidence that sympathectomy will increase arterial flow. It is therefore possible to give many older patients with stasic ulcer a measure of relief despite their advanced arteriosclerosis.

The basis for rational surgical therapy for chronic stasic ulcer is therefore evident from the clinical investigations outlined.

SELECTION OF PATIENTS

The patients selected for evaluation in this study are those who have had long standing venous obstruction of one or both lower extremities with chronic painful ulcers and who have not responded to conservative measures of local support, local chemical treatment, control of infection by chemotherapeutic means and who have in each instance had the local fungus infections adequately controlled. The latter factor, as pointed out by Thompson,[28] is frequently a troublesome complication of stasic ulcer, and may in fact be the major cause for failure of treatment. Many of the patients furthermore, had previous surgery on the superficial venous system ranging from simple ligation to stripping of the saphenous system with local excision and skin grafting of their ulcers as first advocated by Homan[29] in 1917. No patient was included in this series who showed satisfactory response to the conservative measures outlined. Each patient also showed evidence of peripheral angiospasm as demonstrated by cold, moist feet, and tendency to cyanosis upon standing. Comparative studies of skin temperatures were made before and after paravertebral block.

PREOPERATIVE CARE

Each patient received a period of hospitalization preceding surgery. The patient was placed at bed rest with elevation of the affected extremity, local moist compresses, systemic chemotherapy in the form of penicillin, and in several instances the use of tetra ethyl ammonium chloride intravenously. When the edema had subsided to an optimum degree, and the ulcer appeared grossly clean, the patient was subjected to operation.

OPERATION

All cases operated were given low spinal anesthesia. The patient was prepared in a tilt position, a large sandbag under the hip and flexion of the thigh and knee of approximately thirty degrees each. Sympathectomy was then performed after the following method described by deTakats.[30] A segmental incision is made with its mid-point opposite the anterior superior spine and in the direction of the fibers of the external oblique muscle. Dissection is carried in a gridiron manner to the peritoneum. The peritoneum is dissected away from the lateral and posterior musculature, the ureter is retracted with the peritoneum until the aorta or inferior vena cava can be retracted mesially. The second and third lumbar ganglia and communicating branches are then resected. The peritoneum, transversalis and internal oblique muscles are then allowed to fall into place and interrupted sutures are placed in the external oblique muscle and fascia. The sandbag is then removed, the patient returned to a normal position and the entire extremity is prepared and draped. A femoral incision is made, extending from the mid part of the inguinal ligament to the apex of the femoral triangle. The saphenous vein is isolated and its contributary branches divided. The report of saphenous vein is resected to the sapheno-femoral junction. The femoral vein is then dissected, the profounda identified, and the femoral vein interrupted by division immediately inferior to the profunda. The divided saphenous vein is stripped as far as possible by the method introduced by Babcock.[31] If impossible to strip the vein adequately, segmental ligation is performed. Regardless of the local treatment of the veins it is essential to remove the venous channels immediately adjacent to the ulcer. In several instances, in this series, the local ulcer was resected with primary grafting, with a split thickness graft. The operated extremity is then wrapped snugly with Ace bandages and large compression dressings particularly in the thigh area. The patient is kept at bed rest for a period varying from three to ten days, dependent upon the degree of edema present at the time of operation. The patient is allowed up when free of pain and edema. The patient is cautiously ambulated for short increasing periods of time until able to take care of his ordinary needs. All patients were operated with cotton suture technique.

RESULTS OF THE OPERATION

Sixteen consecutive patients were treated in the manner outlined above with minor variations

OPERATIVE TREATMENT AND RESULTS

Case	Age	Duration Symptoms	Previous Surgery	Operation	Result
R.B.	73	38 yr. edema 18 yr. ulcer	Saphenous ligation	Left Sympathectomy Femoral Lig.	Healed Slight edema
A.M.	46	5 yr. edema 2 yr. ulcer	Saphenous ligation	Left Sympathectomy Femoral Lig.	Healed No edema
A.P.	68	3 yr. edema 3 yr. ulcer	Repeated debridement and skin grafts	Left sympathectomy Femoral Lig. Saph. stripping-graft	Healed No edema
A.O.	67	25 yr. edema 5 yr. ulcer	No previous	Left and right sympathectomy femoral lig. saph. stripping lig.	Healed Slight left edema No right edema
S.L.	38	7 yr. edema 7 yr. ulcer	Saphenous stripping	Right sympathectomy femoral lig.	Healed Slight edema
F.B.	52	10 yr. edema 8 yr. ulcer	Saph. lig. mult. Left saph. stripping	Left sympathectomy Left femoral lig.	Healed Mod. edema
W.L.	38	5 yr. edema 5 yr. ulcer	Left saph. lig. 1943 Femoral Lig. 1944	Left sympathectomy	Healed Slight edema
M.H.	69	20 yr. edema ? ulcer	Various palliative	Left Sympathectomy Femoral lig. saph. stripping	Healed Some edema
S.T.	62	12 yr. edema 12 yr. ulcer	Sapr. injections, etc.	Left sympathectomy saph. stripping	Healed No edema
A.G.	67	10 yr. edema 10 yr. ulcer	Saph. stripping Skin graft	Left Sympathectomy Femoral Lig.	Not healed No pain
L.B.	74	15 yr. edema 15 yr. ulcer	None	Left sympathectomy saph. lig. multiple femoral ligation	Healed Mod. to severe edema
L.O.	65	2 yr. edema 2 yr. ulcer	None	Left sympathectomy femoral ligation saph. stripping	Healed No edema
O.N.	70	12 yr. edema 10 yr. ulcer	None	Left sympathectomy femoral ligation saph. stripping	Not healed Regression Slight edema
C.N.	18	2 yr. edema 1 yr. ulcer	Mult. ligation Bilateral stripping	Bil. sympathectomy femoral ligation excision ulcer and graft	Recurrent ulcers No edema
W.S.	44	6 yr. edema 6 yr. ulcer	Saph. Lig.	Right sympathectomy femoral ligation	Healed No edema
J.G.	34	5 yr. edema Arthritis	Bilat. saph. lig.	Bilat. sympathectomy femoral ligation	Healed No edema

depending upon whether or not they had prior surgical treatment to the saphenous system. There were three of these with bilateral operations making nineteen extremities so treated. Of this group the average age, exclusive of one nineteen-year-old male, was 58 years.

Thirteen of the 16 patients and 15 of the 19 ulcers are healed and have not recurred after normal ambulation. The period of follow-up is from two to fifteen months, and is too short to determine the final result. The four extremities that are not healed are found in three patients: (1) A 67-year-old arteriosclerotic male, who has marked regression in his ulcer but will need excision of the ulcer and grafting. (2) An 18-year-old male who had bilateral operation with complete excision of ulcers. The ulcers have reoccurred. This patient had severe edema and pain preoperatively, is now free of edema and pain, but we have been unable to heal his ulcers. (3) A 70-year-old female who has had regression in her ulcer but still has moderate edema of the leg and who will need local excision and grafting.

All patients had ambulatory edema at the time of admission to the hospital. Eight patients have no edema on a full work schedule; six patients have slight to moderate edema after being on their feet four hours or longer, and two patients continue to have severe edema showing little or no improvement over their preoperative state. The table gives a brief summary of each patient.

ILLUSTRATIVE CASE REPORTS

Two cases are presented in detail to illustrate the result in (a) old chronic long standing ulcer in a woman with severe arteriosclerosis, and (b) a relatively young active male with a short history of ulcer unimproved by ordinary therapy.

Case A. Mrs. R. B., aged 73 was first seen in December, 1945, with a huge edematous left leg, approximately three times the size of the right one. There was a large 8 x 3 cm. ulcer over the internal malleolus. She gave a history of thrombophlebitis following delivery thirty-eight years previous with increasing disability and edema, up to this time. The ulcer had been present for eighteen years. She had been unable to do housework for eight years. Saphenous ligations, injections and skin graft had been attempted without success. She disappeared from our service until May of 1948, when she presented the same picture but with a completely encircling ulceration about the left ankle. The left foot and leg were cold, and moist, and brawny induration extended to the knee. She was placed on elevation, paravertebral block, chemotherapy and moist compresses. X-ray of the involved leg showed myositis ossificans, generalized throughout all of the muscles of the left lower leg. The response to paravertebral block was satisfactory with relief of pain and a rise in temperature of 1 to 1.5 degrees C. On June 1, 1948, a left lumbar sympathectomy, external femoral interruption, saphenous ligation and stripping to the knee and biopsy of the ulcer were performed. On March 1, 1949, she had slight

edema with complete healing of the huge ulcer except for a small dry fibrotic area the size of a thumb nail. She is normally ambulatory.

* * *

Case B. A. W., 46-year-old male, a boilermaker, came on the service in June of 1948, with history of pain, edema and induration in the left leg since herniorrhaphy in 1943. He had had serial ligations and saphenous stripping elsewhere with follow-up extending over a two-year period. He developed ulcer in 1945 which persisted despite treatment. He had relief of pain, edema and a reduction in size of ulcer whenever at bed rest for a prolonged period. Examination showed left leg indurated to the knee with large deep ulcer 8 x 6 cm. located above the internal malleolus. The feet were cold and moist. There was no evidence of varices. Hospitalization at bed rest with chemotherapy reduced the induration and edema. Paravertebral block reduced pain and raised the skin temperature 2 to 2½ degrees C. A left lumbar sympathectomy with external femoral interruption was performed in August, 1948. The ulcer healed during the patient's stay in the hospital and he returned to normal duty in three weeks. In March, 1949, he had no edema or pain. There was complete healing of his ulcer on a full work schedule.

SUMMARY

A rational surgical treatment for post-phlebitic or stasic ulcer is presented. It consists of lumbar sympathectomy for angiospasm, interruption of the external femoral vein and resection of the superficial saphenous varices to the ulcer level. In severe ulceration excision of the ulcer and its vascular bed with skin grafting, accompanies the operation.

No untoward results were encountered in sixteen patients operated. Thirteen had complete healing of their ulcers. Eight patients were relieved of all edema, six were improved and two showed no improvement.

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Carcinoma of the Stomach

The charts of 69 patients during 81 hospital admissions for carcinoma of the stomach were studied in relation to the presence of fever and to its etiology: 14.81 per cent of the patients had no fever; 24.69 per cent had fever associated with infection or other pathological conditions exclusive of neoplasm; 12.35 per cent had fever of doubtful origin, it was probably neoplastic but infection could not be entirely ruled out; 48.15 per cent had fever unrelated to any cause besides neoplasm.

It is concluded that low-grade intermittent fever is a frequent sign of carcinoma of the stomach. When infection is eliminated, it will still be present in approximately 50 per cent of the patients with this disease.—Berlin & Porter; Virginia Med. Monthly, Vol. 77, No. 2, Feb., 1950.

The Early Management of Face and Jaw Injuries

BRUCE C. MARTIN, M. D.

THE purpose of this paper is twofold. First to present the problems of face and jaw injuries, and secondly, to plea for early replacement of the foundation structures.

During the past two decades the increase in incidence of face and jaw injuries has been appalling. The war just finished resulted in many thousands of such cases and initiated considerable study of this problem. The military injury is usually caused by high velocity missles. In the case of the civilian injury, the human body is the high velocity missle, and the damage is the result of contact with some unyielding object, most often the dash or windscreen of an automobile.

RESULTS OF DELAYED TREATMENT

Military experience has shown that these injuries profit by the use of a surgical team. The prime object of surgery is the preservation of life, of sight, of function of injured parts, and restoration of contour of the face. Most severe face and jaw injuries will be grouped into that awful category of "head injuries" and will become the recipients of expectant treatment. This period of expectancy will often be drawn out with the result that facial bones will become united in positions of terrible deformity. Eyeballs will be in depressed positions with diplopia, teeth in malocclusion, nasal passages will be occluded, and the general contour of the face flat and dish like. It is not uncommon to read the clinical histories of these patients and find that they were classified as severe head injuries only to see operative reports of extensive debridement of compound fractures of extremities a few hours later. We feel that with cooperation of the surgical team, this dreadful period of waiting can be shortened. With early replacement of facial bones, the foundation structure, extensive and often unsuccessful late plastic procedures can be avoided.

PRINCIPLES OF SOFT TISSUE CLOSURE

I shall not waste time with the problem of preparation of these patients for surgery, other than to emphasize the importance of adequate airway. Anoxemia will rapidly increase the extent of cerebral injury. Little time need be devoted to soft tissue injury, the principles of conservation of tissue, closure in layers, atraumatic technique, careful skin suturing are well known and widely practiced. One must debride tissue with great care. Even in cases requiring rapid closure, sutures should be placed close to the wound edge to prevent extensive ladder marks which may require the sacrifice of valuable tissue later. All fixed points—ala of nose, commissure of the mouth, corners of the eyelids and brows, must be replaced accurately.

Presented before the Section on Surgery at the Annual Meeting of the Ohio State Medical Association, Columbus, April 19-22, 1949.

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PATTERNS OF FACE AND JAW FRACTURES

Injuries to the bones of the face follow certain definite patterns and these depend on which "peaks of contour" received the brunt of the force first. It is of no interest to show photographs of these patients. As far as the surgeon is concerned they all look alike—as Sir A. H. McIndoe says, "They are all brothers and sisters, their only difference is in sex." Their swollen features usually hide their identity.

Probably the most common injuries are those of the mandible. The mandible is almost a bone ring—a fracture in one portion usually leads to a second break. The classical fracture is one in the region of one second molar and opposite mental foramen. When only one fracture is evident, look carefully to the condyle. Its fracture is common and often missed because of poor X-rays. All fractures of the mandible anterior to the ramus must be considered compound because of the intimate attachment to the mucoperiosteum. Teeth in line of fracture must be extracted unless essential to maintaining position. The question of drainage of the fracture site is one of surgical judgment. A fracture of 24 to 48 hours' duration, poorly immobilized, and with considerable laceration of the mucoperiosteum within the mouth will profit by external drainage.

Damage to the middle third of the face will fall into definite patterns. These resemble the ripple one sees when a stone is dropped into water. The nose is the high point and carries the brunt of force. First the nasal bones let go and the first ripple is formed. As the violence increases the nasal bones are driven into the face and the maxillae separate, usually through the maxillary frontal suture, and the infraorbital foramen so that the upper jaw becomes free floating inverted keystone. With increasing vio-

lence the third ripple occurs. The nose is driven deeply into the face like a wedge. The lines of the inverted keystone are extended to include the fracture of the attachments of the zygomas and spreading of the medial wall of the orbit. The orbital floors are usually depressed, diplopia may be present and cerebrospinal fluid leak through the nose is often seen. The entire central third of the face is separated from the skull.

LATERAL VIOLENCE TO FACE

Lateral violence to the face usually takes a rather definite pattern. The malar eminence takes the first blow. This bone promptly lets go its attachments and becomes impacted into the maxillary sinus. The lateral half of the orbital floor is depressed. Often fracture lines run up the medial wall of the orbit and involve region of the pulley and double vision results. I feel that this is more important than position of the globe in regard to diplopia. With increase in violence the opposite maxilla usually lets go through the infraorbital foramen and lateral wall of the antrum.

As one can well imagine there are many deviants from these patterns. The so-called Guerins fracture, which is a simple transverse fracture of the maxilla, is not uncommon. A similar transverse fracture through the superior orbital fissure is occasionally seen. Both of these result from violence applied to the alveolar ridge of the upper jaw.

ASSESSMENT OF INJURY

The proper assessment of the extent of these injuries is largely clinical and is not easy. It is difficult for the surgeon to realize that here "one must treat the patient not his X-rays." X-ray examination may show devastating fractures while clinically there is little displacement. Unfortunately the reverse may be true.

It is at this point that the team play comes into action. The neurosurgeon must weigh carefully the intracranial damage and choose the proper time for intervention. Most procedures for repositioning facial bones can be done at the bedside. Reduction of nasal and ethmoidal plate fractures can be done rather simply by elevation with a knife handle and retained by a mattress suture of stainless steel over buttons behind the nasal bones. This procedure often stops spinal fluid leaks and was found reasonably safe in the European Theater.

TREATMENT

Fractures involving the maxilla and mandible present less of a problem. Simple mandibular fractures almost invariably can be handled by continuous loop wiring with associated elastic traction, as described by Col. Roy Stout, U.S.A., D.C. Edentulous patients present the only problem. Some variations of splint can usually be applied. Where there is no dentition, sectional splints can be made and circumferential wiring done. Fractures of the maxilla can be reduced by traction to the lower jaw, thus placing the teeth in occlusion. When this is accomplished a simple elastic chin strap to head cap will serve to draw the maxilla or the central facial segment in its proper place.

Most external pin fixation devices are to be condemned and their employment is largely due the failure of the surgeon to explore the alternatives a clever dental colleague may have to offer. In the early days of the war, Prof. Kilner made the statement that he doubted whether or not an adequate method of immobilizing a distal edentulous fragment of the mandible would be found. I believe Kilner's doubts were justified—certainly the uncertain and often dangerous external fixation devices have not been the answer.

The depressed fracture of the zygoma with its associated fractures of the maxilla are common. Several approaches to this problem have been used. Sir H. D. Gilles has described the temporal approach for elevation of this structure. This procedure is excellent for elevation of the fractured arch but as for elevation of the malar compound is less than useless. There is usually a comminutation of the orbital floor with depression, blood and often loose bone fragments in the antrum. Any operation devised for repositioning this bone must consider these factors: (a) to drain this compound fracture, and (b) elevate the orbital floor. One must enter the sinus through the Caldwell Luc approach. The orbital floor is repositioned under direct vision. The antrum is cleared of debris. Drainage can be provided into the nose and the position of the zygoma maintained with packing.

In conclusion, "Injuries of the facial bones demand immediate and prompt attention to prevent permanent deformity. (2) The management of injuries of the bones of the face is a team proposition. (3) Management of soft tissue injuries of the face, in the acute phase, is secondary to that of the foundation structures."

Experience and Wisdom

Remember that experience is never finished and wisdom is never complete; that we are always more likely to meet the common than the unusual, but that what appears at first to be a simple and familiar clinical problem may yet be something we have never met, even something hitherto unrecorded; that no problem is so straightforward that it does not need careful study, or so difficult that some solution will not appear if we seek steadfastly.—Sir Heneage Oglivie, K.B.E., British Medical Journal, No. 4629, September 24, 1949.

Diagnosis and Treatment of Acute Thrombophlebitis

LAWRENCE N. ATLAS, M.D.

IT IS NOT appreciated sufficiently that acute thrombosis of the veins of the lower extremities and pelvis is potentially a lethal and disabling disease. As a complication of childbirth, surgery, debilitating illness, and trauma, thrombi may form in the deeply situated veins of the leg or pelvis. Unless the vein reacts to the thrombus which it contains by becoming inflammed, the pathological process is asymptomatic. For that reason, extensive peripheral thrombosis with fatal pulmonary embolism may occur with no premonitory symptoms or signs. Conversely, phlebitic reaction to thrombosis with manifest fever, pain, edema, and regional tenderness to palpation may not supervene until the patient has survived pulmonary embolization.

The Author

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DIAGNOSIS

Symptoms and signs are dependent on the location, extent, and intensity of the acute phlebitic process. In a majority of instances, thrombophlebitis originates in the deep veins of the calf musculature; and subsequently may extend into the popliteal, femoral, and iliac veins.

Acute thrombophlebitis of the deep veins of the calf manifests itself by moderate fever, deep-seated pain and tenderness in the calf musculature, and a positive Homans' sign. The latter consists of pain produced in the calf musculature by passive dorsiflexion of the foot. There may be some reflex arterial spasm with subjective and objective coldness of the foot.

Edema of the ankle and leg does not appear until the femoral vein becomes inflamed and occluded sufficiently high to obstruct drainage from the profunda femoris and great saphenous veins. At this stage fever, pain, and regional tenderness are more pronounced. In the thin subject, the thrombosed and inflamed popliteal and femoral veins may be felt as firm, tender tube-like structures.

Massive edema of the entire lower extremity with severe pain and high fever indicate obstruction and inflammation of the iliac vein. This is the stage of so-called milk leg or phlegmasia alba dolens. Phlegmasia alba dolens may appear suddenly without premonitory symptoms and develop with great rapidity; and when it does, thrombosis of the pelvic veins with extension into the iliac vein should be suspected.

Acute thrombosis and/or inflammation of the femoral or iliac veins may induce, by virtue of a spinal cord sympathetic nerve reflex, intense spasm of the adjacent artery. The limb becomes ischemic and may simulate the clinical picture of acute arterial thrombosis with coldness, pallor or cyanosis. In fact, the arterial spasm may, if not relieved, eventuate in thrombosis and ultimate gangrene of the foot and leg. This is more apt to occur in the elderly with sclerotic peripheral arteries. Reflex arterial spasm complicating acute ilio-femoral thrombophlebitis can be distinguished from primary ilio-femoral arterial thrombosis by virtue of the fact that in the former, the ischemic limb is swollen and the superficial veins distended; while in the latter, the limb is shrunken and the superficial veins collapsed.

Within recent years, an X-ray technique for visualizing the venous pattern of the lower extremity has been perfected. Venography is proving to be invaluable for confirming the diagnosis of deep venous thrombosis and in locating the site of the thrombotic process. It is employed routinely when the signs and symptoms of peripheral thrombophlebitis are suggestive but equivocal, when it is necessary to determine whether the thrombus has extended into the popliteal or femoral vein (the importance of this will be discussed under treatment), or when a patient has suffered pulmonary embolization and it is desirable to locate the source of the embolus.

TREATMENT

Prophylaxis is important. Early ambulation following parturition and surgery reduces the incidence of thromboembolic complications. If ambulation is not feasible, the patient should be encouraged to move his legs. Active or passive "bicycle" exercises are particularly good. Surgical stirrups which exert pressure on the calf or popliteal space should be well padded, as should all straps which bind the legs down to the operating table. If the patient gives a history

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of a previous attack of thrombophlebitis, anticoagulants are administered prophylactically.

In so far as active treatment of manifest thrombophlebitis is concerned, there are fundamentally two distinct approaches to the problem: the inhibition of intra-vascular clotting through the use of anti-coagulant drugs; and the mechanical blocking of thrombosed veins by surgical exploration and ligation of the femoral vein. While each method has its enthusiasts to the exclusion of the other, both methods have their place depending on specific indications.

Anticoagulants are preferred:

1. When the thrombophlebitic process is limited to the leg and has not extended into the popliteal vein; and the patient has not suffered an episode of pulmonary embolization. Under these circumstances, anticoagulant drugs inhibit the spread of the thrombotic process during that period when the thrombus already present becomes fixed to the vein wall and the phlebitic process subsides.

2. When the condition has progressed to the stage of phlegmasia alba dolens. After the iliac vein becomes thrombosed and inflamed, pulmonary embolization rarely occurs. In addition to inhibiting further thrombus formation, anticoagulant drugs seem to expedite resolution of the phlebitic process; and it has been my observation that the severe pain, high fever, and massive edema associated with acute iliac thrombophlebitis subside quite rapidly when anticoagulant drugs are administered.

3. When an individual has experienced pulmonary embolization and the source of the embolus cannot be determined. While it is true that the majority of pulmonary emboli come from thrombosed veins within the lower extremities, they can and do originate elsewhere; and when they do, an ill-advised femoral vein operation is worse than useless.

Femoral vein surgery is preferred:

1. When it can be demonstrated that the popliteal or femoral vein contains a thrombus, particularly if the attendant phlebitic reaction is not sufficiently intense to fix the thrombus in situ. It should be borne in mind that anticoagulant drugs have no effect whatsoever on a thrombus which has already formed; and that the detachment of a large thrombus from the popliteal or femoral vein is responsible for fatal pulmonary embolization. In view of the grave risk attending popliteal and femoral vein thrombosis it is safer to surgically block egress of emboli by means of femoral vein ligation than to depend on anticoagulant drugs.

2. When it can be determined that the peripheral thrombotic process responsible for an episode of pulmonary embolization is within the leg or thigh. An initial episode of non-fatal pulmonary embolization will be followed, in 50 per cent of cases, by other episodes; and each succeeding attack carries a greater risk of mortality. The prevention of repeated episodes of pulmonary embolization constitutes a major therapeutic problem. Surgical prophylaxis, when indicated, is unquestionably the ideal procedure.

The treatment of reflex ilio-femoral arterial spasm must be prompt and vigorous if arterial thrombosis is to be prevented. Paravertebral injection of procaine into the lumbar sympathetic ganglia is effective and dependable only when performed by one skilled in the use of the method. The intravenous administration of tetra ethyl ammonium chloride (Etamon) is an effective substitute for paravertebral block. Since relaxation of spastic arteries is followed by a marked increase in peripheral blood flow, a loosely attached thrombus may be "washed out" of the limb with resultant pulmonary embolization. This eventuality can be prevented by a preliminary femoral vein ligation.

THE TECHNIQUE OF ANTICOAGULANT THERAPY

There are two substances available each of which is effective in inhibiting intravascular clotting. They are heparin and dicumarol. Heparin acts directly on the intravascular blood clotting mechanism by neutralizing thrombokinase. It is administered either intravenously or intramuscularly. Once injected its action is immediate. However, the effect of a dose of 50 mgs. is not longer than four hours. A transfusion of freshly drawn whole blood counteracts the effect of heparin at once and is a very effective antidote.

Dicumarol acts indirectly on the intravascular blood clotting mechanism by interfering with that portion of liver function which is concerned with the formation of prothrombin. It is administered orally, and twenty-four to forty-eight hours must elapse before its effects become manifest clinically; but once ingested, the effects of the drug may continue for a week or

longer. In a sense, dicumarol is a liver poison. Should it become necessary to increase the prothrombin content of the blood, this can be accomplished only by repeated transfusions of freshly drawn whole blood and by attempting to reverse the toxic hepatic disfunction by administering large parenteral doses of vitamin K.

A routine for administering anticoagulant drugs has been established. As a preliminary control, the prothrombin activity of the blood is determined by suitable laboratory procedures. A single dose of 300 mgs. of dicumarol is then administered orally; and to cover the lag in time before it becomes effective, heparin is also started. A dose of 50 mgs. is injected either intravenously or intramuscularly every four hours for forty-eight hours. It has been my practice of late to administer heparin by deep intramuscular injection. If a small quantity of procaine is added to the heparin solution, deep intramuscular injection is painless, safe, and very effective. On the morning of the second day and every morning thereafter, prothrombin determinations are done. An attempt is then made to establish a maintenance dose of dicumarol which will keep prothrombin activity within the range of 25 to 35 per cent of normal.

Evidence of abnormal bleeding must be looked for particularly from the gastro-intestinal tract and kidneys. Anticoagulants should not be used in the presence of liver disease, tuberculous cavitation, gastro-intestinal ulceration, or any other condition where hemorrhage could prove disastrous.

THE TECHNIQUE OF FEMORAL VEIN EXPLORATION

The operation is usually performed under local infiltration anesthesia. A vertical incision is made over the proximal three inches of the femoral vein and continued upwards over the external iliac vein where it crosses the horizontal ramus of the pubis to enter the pelvis. The great saphenous vein is exposed and its junction with the femoral vein defined. Care is taken not to injure the great saphenous vein since it serves as an important collateral. The upper portion of the femoral vein, the junctions of the profunda femoris and great saphenous veins with the femoral vein, and the lower portion of the external iliac vein are visualized. Two silk ligatures are passed around the femoral vein between the saphenous and profunda femoris veins. (It is an error to ligate below the profunda femoris. A thrombotic process occasionally develops in the profunda femoris system in the thigh and may extend into the common femoral vein if the ligation is performed below the confluence of the profunda femoris and superficial femoral veins.) The femoral vein is opened between the ligatures. All thrombotic tissue extending beyond the contemplated point of ligation is aspirated; and when a free flow of blood from the proximal portion of the vein is obtained, the ligatures are tied. The vein is sectioned if there is sufficient space between the ligatures to do so safely.

A Modern Tendency

There is a modern trend for the members of various specialties to gather together and seclude the radiographs illustrating conditions with which they deal, and the X-ray departments and hospitals are so much the poorer because this valuable material is lost to the general use of the hospital and the special use of the radiologist. Radiology knows no bounds of specialization. The radiograph is a measure of the relative density and a record of the contrast outlines and structures of all tissues on and between the two skin surfaces which bound the area. We therefore need radiologists who understand all the evidence presented to inspect the whole, for there is a tendency on the part of specialists to be obsessed by evidence which appears to involve their specialty. Only good can come from whole-hearted co-operation, but harm will result to patients from seclusion and isolated activities, for which the responsible person may be called upon to bear the blame.

Requests for X-ray examinations are made on forms which have a space with some such heading as "Conditions revealed by the clinical examination on which radiological evidence is required." Those clinicians who co-operate and desire all the help which the radiologist can give, the men who really taught me my radiology, fill in this space with facts gleaned from the clinical examination that are invaluable to the radiologist. Those men who ape a knowledge of radiographic technique and want the radiographs, but no assistance otherwise, use this space for giving instructions with certain cryptic signs, designed to impress the radiologist with their great knowledge of radiographic technique, such as, "A. P. and L.," and if they wish to display their profound knowledge they add also, "P. A. and oblique." Such requests fail to convey any suggestion of confidence in the radiologist, and certainly do not invite him to share the responsibility; consequently he loses the stimulus for good work and the patient suffers accordingly from the defective interpretation of the radiographs.

Radiography, together with other ancillary services to clinical medicine, is being used extravagantly and is one of the chief contributors to the increased cost of medical service.—James F. Brailsford, M. D., British Medical Journal, No. 4630, October 1, 1949.

Primary Torsion of the Great Omentum: Case Report

DAVID B. GILLIAM, M.D.

PRIMARY torsion of the great omentum is a rare condition, there being very few cases reported in the literature. By primary torsion is meant a twisting of part or all of the omentum on its axis, not associated with hernia or adhesions to abdominal viscera. Eitel reported the first case of this kind in 1899.

I have recently operated upon a case of this kind which was diagnosed as acute appendicitis.

The Author

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CASE REPORT

A male, aged 34, white, married, was employed as a taxicab dispatcher in a small nearby city. He had previously enjoyed excellent health. Thirty-six hours before admission he began to have sharp pains in the abdomen, but continued to work. On returning to his home he went to bed thinking the pain would wear off. The pain did not abate but became worse and he called his physician who referred him to St. Anthony's Hospital with a diagnosis of acute appendicitis. On admission his temperature was 102.6; pulse 116; and respiration 32. He appeared intensely ill and the abdomen was very rigid. The greatest point of tenderness to palpation was over McBurney's point. There had been no nausea or vomiting. The white count was 26,200 with 85 per cent total neutrophils. The urinalysis was negative. Immediate laparotomy was indicated, the tentative diagnosis being acute appendicitis.

The abdomen was opened by a right pararectus incision. There was a large amount of serosanguineous fluid liberated under tension. Almost immediately a large darkened mass presented itself in the abdominal incision. This was brought out of the abdomen and identified as omentum which was rolled on itself and twisted very tight at the proximal attachment to the transverse colon. It was suspended by a cord like twist about an inch in diameter and looked like an umbilical cord with large dilated veins. It was a volvulus of the great omentum which had twisted on its axis six or seven times shutting off the circulation and resulting in hemorrhage and necrosis. There was no surgical difficulty in removing this mass. The narrow section by which it was suspended was crushed between two Kocher artery forceps, cut between, and the mass removed. The proximal stump was ligated with catgut. The appendix was removed prophylactically. A Penrose drain was inserted to carry off the remaining abdominal fluid and the abdomen closed in the usual manner. The drain was removed in twenty-four hours and healing was uneventful. He left the hospital in eleven days.

The pathological report on the specimens removed was as follows:

Gross: The specimen consists of an omentum and an appendix. The omentum is extremely large weighing 700 grams, it shows extensive hemorrhage and some areas of fibrous thickening. The appendix is 4.5 cm. long, 8 mm. in diameter and is intensely congested.

Microscopic: Sections of the omentum show extensive areas of hemorrhage and exudation. The lumina of the vessels is occluded by clots which in some instances appear to be of ante mortem nature. The lumen of the appendix contains some blood clot and mucus. The mucosa is intact. The wall shows no abnormality.

Diagnosis: Hemorrhage and necrosis of omentum, probably due to strangulation.

COMMENT

Cowell who, in 1924, reviewed the literature of torsion of the omentum unassociated with hernia found only 18 cases reported. McWhorter, in 1928, increased this number to 26, which included two personal cases. Of these 26 cases 18 were in males, the average age being 38 years. The youngest patient was one year old.

Omental torsion is only one of many conditions which may present the general symptom complex suggestive of acute appendicitis. One should consider perforated duodenal ulcer, ruptured gallbladder, acute pancreatitis, intestinal obstruction, ureteral calculus, and diseases of the genital adnexa in male and female. Many of these conditions give rise to a general symptomatology of grave intra-abdominal disease which calls for immediate surgical intervention.

Appendicitis presents itself under so many varying forms that in a case of omental torsion a correct preoperative diagnosis could at most not be more than a guess. For this reason, the diagnosis of omental torsion, in nearly all recorded cases, where the lesion occurred unassociated with hernia, was a postoperative one. Of course there is always the possibility that a primary torsion of the omentum may be associated with an acute appendicitis. Removal of the omentum is not dangerous to life as the principal function of the omentum is to protect the intestines and other abdominal viscera from injury. The prognosis of surgical removal of the omentum is favorable. McWhorter states that the operative mortality of all cases reported is less than 14 per cent.

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The Purpose of Receiving Hospitals

EUGENE E. ELDER, M.D.

THE purpose of Receiving Hospitals should be threefold. One, treat mentally ill patients immediately in regard to acute mental conditions with enough strength to give necessary treatments any time of the day so that sedatives, which do actual harm to mental patients, should not be used. In our experience, shock treatments are the best sedatives and with it sleep can be restored with a few treatments and physical restraints are avoided, as well as long excited and confused periods of hospitalization. This is especially true with depressed and agitated patients, also some manics, because of their mental activity and antagonism toward sedatives. In one way the overactivity of the brain and in the other the oppressive effect of sedatives are so antagonistic that the patient will become more confused and more restless and sleepless. This applies especially to barbiturates.

If we compare the treatments previous to the shock treatment era, we can recall how a manic patient spent four or five months in hospitals under ten to twelve grains of luminal, in divided doses, usually one, and one-half grain tablet each three hours, including night doses. Very seldom did this medication change the patient's mental condition or shorten much the period of hospitalization. In fact, the illness lasted four to six months whether any medication was given or not. In addition to this, acutely disturbed patients were always in physical restraint.

PRESENT TREATMENT

How different people are treated now, with intensive electric shock treatment as soon as they arrive in Receiving Hospitals. The manic period of extreme restlessness and noisiness quiet down in three to four days, having two to five electric shock treatments, following which a moderate number of treatments are given, two or three per week. In most cases no physical restraint is necessary. The same applies to catatonic excitement, depressed and agitated conditions. Even in the organic group, for example in paretics, a few electric shock treatments are in order if they are unmanageable and overactive until such time as fever therapy can be started. Even in these cases, shock treatments act as a good sedative.

With such immediate and intensive treatments we cut down the hospital stay of patients an average of five weeks. Our results were 75 per cent home remissions with an average of 14 per cent to 17 per cent readmissions. These readmission cases receiving the same treatments as previously and sent home again. Of course, in treating mental cases one has to be aware of the fact that patients usually go back under the same home conditions in which they became ill. The same hysterical mother in one case, the same stepmother in the other, or the same alcoholic husband in another case. Very seldom is it possible to change the home environment during the five weeks the patient is hospitalized with us, although patients are followed to their home environment by the social worker, who tries to help and explain the wrong influences of in-laws or other unhealthy conditions. To arrive at a 75 per cent home remission of the average mental case, we need much more help, more nurses and attendants.

Submitted May 18, 1949.

The Author

● **Dr. Elder, Youngstown, Ohio, is a graduate of University of Budapest, 1922; superintendent, Youngstown Receiving Hospital.**

DISTRIBUTION OF PERSONNEL

According to the American Psychiatric Association the regulations are one nurse for each four patients, and one attendant to each six patients, which should be followed. During the four years of operation of our hospital, we had almost fifteen registered nurses and fifteen to sixteen attendants to an average of 75 patients in the house. Of course, this help was divided into three shifts. The turnover of nurses and attendants was quite large during 1948, approximately 51, but we were always able to secure new nurses and attendants for replacement, so that we were able to give treatments at any time during the day, also the necessary emergency care during the night.

We do not believe that we should wait until cardiography and chest X-rays are made in order to qualify for electric shock treatment, because of the invaluable loss of time. It is remarkable to see a patient who had the first good night's rest in months, having received all the possible barbiturates before admission, change for the better after a few treatments, restored to sleep and on the road to recovery. Of course, there are some patients whose physical conditions do not warrant shock treatments, like seniles, decompensated heart conditions, or

other physical deformities, who have to receive some mild sedation, and in this regard, especially in sclerotics, we find theominal very helpful. In general, however, as to acute mental cases with confusion and hallucinations, we do not use any sedatives.

The second purpose of Receiving Hospitals is to avoid legal commitments with permanent court records, court procedures, also hearings and exposures, and waiting in jails for vacancies in State Hospitals. The majority, about 65 per cent, of the patients were voluntary and came to the hospital on their own initiative for treatments, signed a voluntary admission form and with this signature underwent all the treatments needed; electric shock treatment, insulin shock treatments, narcosynthesis, etc.

Only about 10 to 15 per cent of the admissions had to be court placement cases, because of law violations, homicidal or suicidal tendencies or refusal to sign voluntary admission forms. However, in these cases there is no permanent court record. Therefore, they are called court placements and not court commitments. About 8 to 10 per cent of the admissions are emergency cases, who are so disturbed that they cannot be handled at home. They are usually seniles or arteriosclerotics who are waiting here for State Hospital commitments.

RECORD MAY BE STIGMA

Having a permanent record at the Probate Court is not indifferent to a patient who may have only one mild manic attack during his whole lifetime, for which he was called and branded as irresponsible, insane or lunatic, not able to sign a document and deprived of his legal rights for a long term. But more than the legal rights he was hurt more as an individual in case of marriage or other legal procedures. The person's records may be seen at the Probate Courts. In the case of a reactive depression, due to a person's misfortune out of his control, this person could not marry because of a court paper marking him irresponsible or lunatic, in the old phraseology. This is all past history because any patient may come to the Receiving Hospitals and be handled as a voluntary patient without any court documents on him, providing he signs a voluntary admission form.

The third important purpose of Receiving Hospitals would be to educate and train interns, residents and nurses in psychiatry, psychodynamics and psychosomatics. This is much harder to fulfill especially in hospitals having no university medical school affiliation. Others not having this affiliation are Summit County, Massillon, Dayton and Toledo Receiving Hospitals. Columbus, Cincinnati and Cleveland Receiving Hospitals have the advantage of possible university medical school affiliation.

KEEPING UP WITH MEDICINE

• IN the genesis of heart failure, the important point is that the organ blood flow is not adequate.

* * *

• SERUM albumin seems to be of some help in the treatment of severe pre-eclamptic toxemia by replacing the lost serum albumin and increasing the urinary output.

* * *

• I OFTEN wonder why we could not have as intelligent a campaign against alcoholism as we have against cancer, polio, and heart disease.

* * *

• PHYSICIANS are prone to consider nasal vasoconstrictors an innocuous preparation to be dispensed freely, and used at the patient's discretion.

* * *

• WITH respect to the possible role of the "new vitamin for guinea pigs" in human nutrition, it is intriguing to speculate on the possible relation between the wrist stiffness in the guinea pigs and arthritis in the human being.

* * *

• BESIDE the absence of an organic cause, there are two features that are characteristic of psychogenic headache. First, it is described as being continuous in a way that no headache induced by organic disease could be. Secondly, the manner of the description is often typical and this in itself is but another symptom of the underlying mental state.

* * *

• THE building-up of the individual who is underweight, in the absence of disease, resolves itself into an analysis not only of the previously observed dietetic regimen, but also of the daily habits.

* * *

• IN pediatric practice, streptomycin has become of utmost importance in the treatment of meningitis due to H. influenzae type B, chronic bacillary urinary tract infections, pertussis, and tuberculous meningitis.

* * *

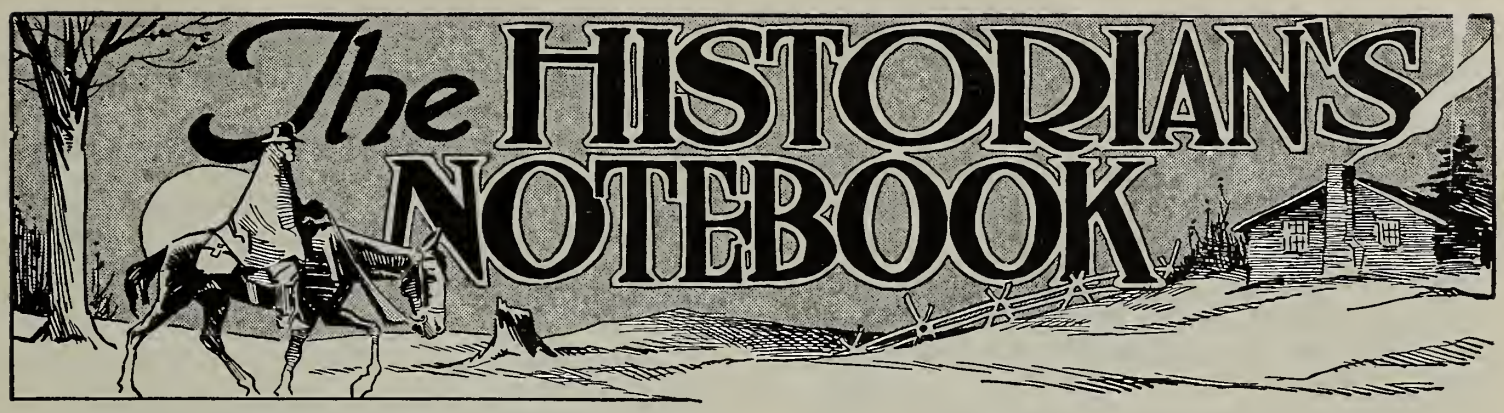
• THE occurrence of bilateral cataract in eyes of young adults that were previously normal, has been reported innumerable times as being caused by allergic reactions.

* * *

• SIXTY-SIX per cent of persons over 75 years of age in this country die from cardiovascular-renal diseases.

* * *

• WITH the widespread use of antibiotics, many physicians have unfortunately come to believe that acute appendicitis is no longer a serious disease. This concept is still dangerous.—J. F.



James E. Bauman's Service to the State of Ohio

ROBERT G. PATERSON, Ph.D.

PART I

I FIRST met "Jim" when I became Executive Secretary of the Ohio Society for the Prevention of Tuberculosis in May, 1911. He was a veteran then with almost twenty years of service. From that date down the years until today, Jim has always been a "tower of strength" not only to the tuberculosis movement but to the entire field of public health in Ohio.

Throughout the years, especially after 1904, Jim has either drafted alone or in cooperation with others practically every health law to be found in the Ohio Public Health Manual. In pursuing this task he was ever cognizant of the state of public opinion at the given moment and constantly exerted a restraining influence upon those of us who were impatient with the slowness that seemed to characterize public opinion, legislative action and governmental controls. He not only aided in molding the shape and form of public health in Ohio but the individuals as well with whom he worked, and I was one of them.

HOST WOULD TESTIFY

There are a host of others who would bear similar testimony if they could be heard today. A few of the early workers are present in this audience—Dr. J. H. J. Upham, Dr. Herbert M. Platter, William C. Groeniger, Dr. Lear H. Van Buskirk, Leo F. Ey and Dr. Emery R. Hayhurst.

Among the many written expressions of the influence Jim exerted I have selected two that seem best to reflect that influence.

Dr. Frank G. Boudreau, Director of the Milbank Memorial Fund, New York City, writes:

> "You took me under your wing soon after I arrived in Columbus in 1911, and from then until 1925, when I left for Geneva you were certainly the most important influence in my life and work. You might dispute the fact that I learned any law through my contact with you, but I did learn the importance of precision in thought and speech, besides picking up a few ideas about printing and proof-reading. I do not wish to hold you responsible for my course in life, but I do say that your influence and teaching helped me in my successes and were not implicated in my failures.
>
> "Quite a number of your apprentices, like myself, who from time to time left you to make their own way in the world, owe you a debt of gratitude for the care and friendship which you lavished on them in their formative years. I wish I could turn the clock back, and accompany you once more to a meeting of township and village health offices, to hear and answer such questions as, 'What do you do when you fumigate a house if a dog has been in contact with the patient?'
>
> "These good old times do not come back but the memory of you and your work is just as fresh in my memory as if we had been working together in 1949 instead of 1911."

WARMEST ADMIRATION

Dr. Allen W. Freeman, at present consultant to the Department of Health, State of Maryland, former Commissioner of Health of Ohio and later professor and dean of the School of Hygiene and Public Health at Johns Hopkins University in Baltimore, has written:

> "I wish with all my heart that it were possible for me to come to Columbus to do honor to old Jim on this occasion. Although nearly thirty years have elapsed since we worked together during the period of my service in Ohio, I have retained for him sentiments of the highest and warmest admiration and affection. Unfortunately, my physical condition is such that I find it necessary strictly to limit my activities, and it is impossible for me to undertake so long a journey."

How can one compress in the time allotted, the fifty-seven years of service Jim rendered in behalf of the health of the people of Ohio? It is obviously impossible. So I have elected to select certain peaks in the development of health legislation in Ohio as illustrative of the kinds

Read at the presentation of a plaque to the Department of Health of Ohio, in honor of James E. Bauman, Tuesday, December 20, 1949, State Office Building, Columbus, Ohio.

of problems that confronted Jim and which he helped to solve.

The peaks I have selected are:

1. Political organization for support of the idea of a state health authority culminating in the establishment of the State Board of Health under Governor Joseph B. Foraker and the work of Dr. Charles Oliver Probst as secretary for twenty-five years from 1886 to 1911.
2. Appeal to the people of the state for a revamping of the organization of the state health organization under Governor James M. Cox and the work of Dr. E. F. McCampbell as secretary from 1912 to 1916.
3. Education of the people throughout the state on the local level for understanding and support of public health work under Governor James M. Cox and Dr. Allen W. Freeman, Commisisoner of Health, 1917 to 1921.
4. The integration of the public health program on the state and local levels under Governor John W. Bricker and Dr. Roger Heering as Director of Health, 1939, and Dr. John D. Porterfield, 1947 to date.

PERIOD I. 1870-1911

Between 1869 when the first State Board of Health was established in this country by the State of Massachusetts and 1886 when Ohio created such a board, the thirty-second in the nation, there are sporadic evidences that a few leading men in Ohio, medical and lay, were busy at the task of trying to interest public opinion to demand such services at the hands of the state government. No one can read the early Transactions of the Ohio State Medical Society from 1870 to 1886 without being aware of the "voices crying in the wilderness."

Among these were Dr. J. R. Black, Newark, Ohio, who in 1870 presented a paper entitled "The Importance of a Concerted Account of the Prevailing Diseases and their Management throughout the State," and in 1871 discussed "Sanitary Science" in which he laid down ten rules or laws designed to secure the health of the individual. These ten rules or laws were:

1. Breathing pure air.
2. Adequate wholesome food and drink.
3. Adequate out-door exercise.
4. Adequate and unconstraining covering for the body.
5. The exercise of the sexual function only for, and no interference with, the normal function of reproduction.
6. A habitation in the climate for which the constitution of the body is adapted.
7. Pursuits which do not cramp or overstrain any part of the body or subject it to the action of irritating or poisonous substances.
8. Personal cleanliness.
9. Tranquil states of the mind and adequate rest and sleep.
10. No intermarriage of near blood relations.

Again in 1873, Dr. Black presented a "Report on a State Board of Health" in which he pointed out the public health evils that existed in the state and said:

> "The remedy for such evils as these is not in a State Board of Health, but in educating the public mind on this subject so that it may perceive the necessity and the benefit which enlightened sanitary legislation is capable of conferring. A State Board of Health, without laws empowering it with a field of control, would be only a state figure-head, or more properly a set of mere closet-office dignitaries, seeking and pleading for some information that would give them a show of usefulness."

All of this, remember, was written almost eighty years ago. It probably is true that in the intervening years we have expanded and refined this program of public health due to more exact knowledge, yet Dr. J. R. Black is one of the neglected pioneers of our public health movement in Ohio. I stress his contributions because they were the first feeble foreshadowing of the kind of work which Jim was able to do in later years.

CONSERVATISM OF PROFESSION

Additional reports were made by Dr. W. W. Jones of Toledo in 1874 on "State Medicine and Public Hygiene" in which he commented upon the conservatism of the profession with respect to this subject. He stated that one "element of this conservatism is found in the dislike (common among the profession) to associate medical truth with the partisan politics of the country and a fear that governmental cooperation would, through its influence, result in failure to advance the true interests of science."

In a report of a Committee on a State Bureau of Health made in 1875 it was stated that two bills on the subject were introduced in the General Assembly. There was a difference of opinion as to whether the State Bureau should be a State Board, consisting of several members, or simply a Commissioner. Neither bill passed.

Dr. E. H. Hyatt, of Delaware, reported for the Sanitary Committee in 1876 that a bill was drafted creating a Sanitary Board, with power to elect a superintendent of vital statistics, at a salary of $3,000. The bill failed to pass because the General Assembly "did not wish, at that time, to create any new salaried offices."

These failures of the General Assembly to act led to the adoption in 1878 by the Ohio State Medical Society of a resolution introduced by Dr. Jonathan Morris, of Ironton, that the Society itself should set up a committee of one in each county to secure reliable information rel-

ative to the prevailing diseases within the borders of the State. It was found that this committee was too unwieldy and in 1880 the committee was discharged and a new one consisting of seven members was appointed.

Dr. D. N. Kinsman, of Columbus, reported on "Sanitary Science" in 1881 and after reviewing the epidemic diseases confronting the profession and the people of Ohio, he concluded with this statement:

> "The establishment of a State Board of Health in the State of Ohio is demanded by political economy, and the humanitarian spirit of the times. This board should be composed of men of known scientific ability, who should be appointed regardless of their political opinions. To this end the Medical Profession should use its influence, and not cease till the purpose is accomplished."

At the 1882 meeting of the Society, the entire problem was discussed again. Dr. Starling Loving, of Columbus, in his presidential address, really took the gloves off and minced no words in taking his colleagues to task in relation to their support of their own State Society; their attitude toward the State Government; their attitude toward Homeopathy; and the failure of the General Assembly to pass a bill in 1881 creating a State Board of Health. Among other things he said:

> "The measure failed, mainly, as I am informed, through the influence of one or two members, assisted by interested lobbyists, who were displeased that homeopathy was not placed in the bill on equality with the regular medical profession, and this, with the non-recognition of eclecticism was the cause of the failure of a similar bill presented some years since."

In this same year Dr. J. R. Black, Newark, again presented a paper on "Preventable Diseases" and Prof. Edward Orton, President of the Ohio State University, read a scholarly paper on "The Relation of the State to Public Health," in which he came out strongly for the establishment of a State Board of Health.

AGITATION BROADENED

On February 14, 1884, Dr. R. Harvey Reed, of Mansfield, removed the agitation for the creation of a State Board of Health from the restricted confines of the Ohio State Medical Society to a broader arena when the organization of the Ohio State Sanitary Association was effected. Its membership consisted of physicians and laymen interested in sanitation and the prime purpose of the Association was to secure a board of health for the State of Ohio.

In his capacity as secretary of the Association, Dr. Reed took the initiative in writing a bill for the establishment of such a board and was active in steering it successfully through the General Assembly.

Joseph Benson Foraker, of Cincinnati, who has been called by Everett Walters in his recent biography of Foraker, "an uncompromising Republican from Hamilton County," was elected Governor in 1885 and took office in January, 1886. In his message to the General Assembly on January 11, he said:

> "It is both prudent and a duty to provide as well as possible against probable dangers, for the protection of the life and health of the people. It is bad policy to delay such legislation, until emergencies against which it would provide, shall have arisen. Such a board ought to be created at once."

The bill establishing the State Board of Health became law on April 14, 1886, and in accord with the provision of the Act, Governor Foraker, on April 23, appointed the members of the first board. It consisted of seven members with the Attorney General, ex-officio, a member. Of the seven members, five were Republicans and two were Democrats. There was one Homeopathic physician, all the others were from the regular profession. Unfortunately, Governor Foraker did not know, or chose to ignore, the long struggle that had preceded the final enactment of the law nor did he know, or again ignored, the men who had labored so diligently to bring the act into being. Not one of the men who had interested himself in the sanitary problem of the state either in the Ohio State Medical Society or the Ohio State Sanitary Association was recognized. The appointments seem to have been dictated purely by political considerations.

FIRST MEETING

The State Board of Health held its first meeting in Columbus on April 30, 1886, and organized by electing Dr. W. H. Cretcher, Bellefontaine, president and appointing Dr. C. G. Ashman, the health officer of Cleveland, as secretary. Dr. Ashman resigned the position in June and Dr. Guy Case of Cleveland was appointed as his successor. Dr. Case resigned July 27 and Dr. Charles O. Probst, of Columbus, was appointed secretary on the same date. His salary was set at $1,600 and the total budget for the work of the board was $5,000. His office was a desk in the office of the Attorney General who out of kindness took Dr. Probst under his wing. Dr. Probst was twenty-nine years of age and had received his degree from Miami Medical College, Cincinnati, in 1882.

This early period is detailed because it had a continuing influence upon the development of the work of the State Board of Health and particularly upon Dr. Probst as its secretary. He had to steer a careful course between the partisan politicians, the widespread and dissident medical theories as represented by the regular, homeopathic and eclectic schools, the resentment of local authorities toward state in-

terference and a profound local ignorance of sanitary matters as well as an indifference in the general population.

That Dr. Probst was successful in his efforts to pacify all these points of view and yet push forward the state program is attested by his twenty-five years as a pioneer public health administrator. No recounting of his services is needed here. The record is available in the Annual Reports of the Ohio State Board of Health from 1886 to 1912; in the Monthly Sanitary Record and its successors from 1888; in Jim's excellent account entitled "Dr. Probst and Public Health in Ohio" in the Memorial Volume dedicated to Dr. Probst in 1934; and in Dr. Probst's delightful paper entitled "Recollections and Reminiscences of Public Health Service and Public Health Workers" written in 1930 for private circulation.

AUGUST 31, 1892

Jim was employed by Dr. Probst on August 31, 1892, as "clerk and messenger with some janitorial duties in addition." Thus began a relationship that gradually grew from employer and employee into one of teacher and pupil, ripened into close professional ties and finally into a warm personal friendship which lasted forty-one years, until Dr. Probst's death on April 2, 1933.

(To Be Concluded in April Issue.)

The Hoyt Family 1839-1949

Two brothers, William and Charles Hoyt settled respectively in Hillsboro and Chillicothe, each heading a line of three generations of homeopathic physicians. William Hoyt I was born in Canada in 1839 and moved to Vermont when he was fourteen. He served three years in the Union Army in the Civil War. He then graduated at the Cleveland Homeopathic Medical College in 1867, and practiced in Hillsboro with honor and success for 52 years—until his death. The records show he delivered almost 4,000 babies in those days when all were home deliveries with few hospital facilities or trained nurses. He also occupied many positions of trust in his community.

His son, William Hoyt II, is a graduate of Hahnemann College in Philadelphia, and is now one of the representatives of the homeopathetic school on the Ohio State Examining Board, in his third term. At home he had been County Health Commissioner for fifteen years and County Coroner for fourteen years. Dr. W. M. Hoyt II practiced with his father occupying only three different office locations in 81 years, and in this office is an unbroken record of every case treated from the first prescription of Dr. Hoyt I in 1867 until the present time, a record difficult to duplicate anywhere.

Dr. William Hoyt II has one son, Charles Wm. Hoyt, who also graduated at Hahnemann College in Philadelphia, and after eight years of practice, is specializing in anesthesia in a two-year course in Philadelphia at Hahnemann.

Daughter Annie of Wm. Hoyt I also studied medicine, graduating from Pulte College in Cincinnati, and studied for one year in Germany. She practiced with her father until her marriage to Dr. W. B. Robinson, and their oldest child graduated from Yale Medical College and practices at Mt. Gilead, Ohio.

PIONEER PRACTICE

It seems that there should be some outstanding story out of the pioneer practice of Dr. Wm. Hoyt I and here is what was hastily remembered by his son, Dr. Wm. Hoyt II. "There were many experiences similar to other doctors of the period, and unusual events such as delivery of a baby where the people lived in a house with only a roof and three sides, the fourth being open for an open fire with no semblance of fire-place or chimney, the floor but the bare ground, the bed but a pile of leaves with grain sacks over them; of attending the great-grandson of a full-blooded Cherokee Indian Chief right here in this territory; of a case of pneumonia treated in a house where you could stand by the bed and look out through cracks in the roof and see the snow flying; of operating on a ruptured appendix with the child on the top of the sewing machine and only the wash boiler for sterilizer and shaped ether cone from bailing wire, and where the cracks of the floor were so wide you could stick your hand through and scratch the pigs on the head, and having the patient get well; of a patient who apparently thought he could walk on water (as the Bible relates) but sank; of examination of a woman who pulled a dog out from her feet under the feather-bed as a foot-warmer, and many more that are similar."

CHARLES HOYT

The youngest brother of Dr. Wm. Hoyt I, Charles Hoyt, got his medical education at Pulte, Cincinnati, graduating in the late seventies. He located in Chillicothe, Ohio, in 1881, and started another family line of homeopathic physicians. He was president of the Ohio State Homeopathetic Society in 1913. His oldest son, Loy, graduated from Hahnemann in Philadelphia in 1909, and practiced with his father until his death, and is still in active practice. Loy's oldest son, Charles, graduated from Physicians & Surgeons in New York. He served in the armed forces in the last war and is now associated with his father in Chillicothe. Every one of the Hoyt family have carried on the family medical traditions in a record almost impossible to equal in quantity and quality of high service—

LUCY S. HERTZOG, M. D., Chardon, Ohio.

Time to Make
Hotel Reservations



for the

1950 Annual Meeting
Ohio State Medical Association
Cleveland, Ohio . . . May 16, 17, 18

NAME AND LOCATION	SINGLE	DOUBLE	DOUBLE TWIN BED
ALLERTON HOTEL, 1802 E. 13th St.	$3.50-6.50	$5.50-10.00	$6.00-10.00
AUDITORIUM HOTEL, 1315 E. Sixth St.	$3.50-3.75 $4.50-5.00	$5.50-6.00 $7.00	$7.50 and Up
CARTER HOTEL, PUBLIC SQUARE	$4.75-7.00	$7.00-10.00	$8.00-12.00
CLEVELAND HOTEL (Headquarters Hotel)	$4.50	$6.50-9.00	$9.00-14.00
HOLLENDEN HOTEL, 610 Superior Ave.	$3.50-8.00	$5.50-10.00	$7.00-14.00
OLMSTEAD HOTEL, Superior & E. Ninth	$3.00-6.00	$5.00-8.00 $7.00-9.50	$7.00-9.50
STATLER HOTEL, Euclid at E. 12th St.	$4.00-6.00	$7.00-10.00	$8.00-12.00

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Hotel, Cleveland, Ohio

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 16, 17, 18, 1950, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price .....

☐ Twin Bed Room with Bath ☐ Suite

Arriving May .....at.....A. M.....P. M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

.....



Photo Courtesy The Wooster Daily Record

Annual Meeting Instructional Courses . . .

Fourteen Informal Discussion Groups Will Provide Doctors With Wide Range of Subjects From Which To Choose At Cleveland Session

ONE of the popular Educational features of the Annual Meeting in Cleveland, Tuesday, Wednesday and Thursday, May 16, 17 and 18, will be the series of Instructional Courses. Since these courses were instituted as a part of the Annual Meeting scientific program several years ago, they have become more and more popular with members.

For the benefit of those who have not had an opportunity to attend any of these courses, here is how they are conducted. The "class" consists of from 50 to 100 doctors who have previously made reservations for a particular course. The discussion is conducted by a moderator and a panel of three or more clinicians, each of whom is a recognized authority in a particular phase of the subject under discussion.

No formal presentations are made. After each discussant has had an opportunity to orient the audience on his phase of the medical topic, the moderator throws the discussion open by directing questions to the various members of the panel. Questions from the audience usually are the basis of the major part of the discussions. Every effort is made to keep discussions meaty and to the point. Problems are discussed from the standpoint of the physician in everyday practice.

Attendance to the Instructional Courses will be limited. Admission will be by ticket only. Therefore, those who plan to attend should apply for tickets in advance of the meeting.

A special folder on the Instructional Courses and other Annual Meeting events will be mailed to each member in the near future. This folder should be read carefully since it will give information on how to secure Instructional Course tickets.

An application envelope for ordering Instructional Course tickets will accompany the folder. This envelope should be filled out, per instructions, and mailed to the Columbus Headquarters Office where applications will be filled. Because of limited facilities, applications will be filled on a first-come, first-served basis. Tickets will be mailed well in advance of the meeting to those who apply.

There will be no registration fee for the courses, nor will there be a registration fee for any of the scientific sessions.

The Committee on Scientific Work under the chairmanship of Dr. Martin W. Diethelm,

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The Instructional Courses constitute only one phase of the vast Scientific Program of the 1950 Annual Meeting. Other features include: **General Sessions** at which Specialty Sections will present programs to the interest of physicians in all branches of medicine; **Medical Topics of the Day,** panel discussions in which clinical procedures are emphasized; **National Affairs,**— talks by Senator Robert A. Taft of Ohio and Dr. George F. Lull, secretary and general manager of the A. M. A.; **Scientific Exhibits, Technical Exhibits, Meeting of the House of Delegates, Auxiliary Meeting, Annual Banquet.** The complete program of the 1950 Annual Meeting will be publishsed in thhe April isssuse of *The Journal.*

On the facing page, the Cleveland Hotel, headquarters for the 1950 Annunal Meeting, is superimposed over an aerial view of University Hospitals, adjuncts of the Western Reserve University School of Medicine.

The Cleveland Hotel is a landmark of the city, well known to previous convention goers. The University Hospitals, although not playing a direct part in the scientific program of the Annual Meeting, are keystones in the history and progress of medical education and medical practice in Ohio. All scientific features of the Annual Meeting will be held in the Cleveland Public Auditorium.

Toledo, has invited as moderators for these courses physicians, each of whom is known, not only as an authority in his field, but as a capable instructor.

The scientific program for the 1950 Annual Meeting will get under way on Tuesday, May 16. The first of the series of Instructional Courses will be held from 9 to 10:30 a. m. on Wednesday, May 17. The second series will be held from 10:30 a. m. to 12 noon, also on Wednesday. The third series will be held Thursday from 10:30 a. m. to 12 noon.

This means that a doctor may include in his schedule three complete Instructional Courses, in addition to the other scientific features being offered. These refresher courses offer an excellent opportunity for physicians to discuss daily practice problems with authorities in the various fields of medicine.



A. C. ERNSTENE, M. D.
Moderator, Course 1
"Treatment of Heart Disease"

Following is a list of subjects to be covered in courses with brief description of each:

Course 1—"Treatment of Heart Disease," Wednesday, May 17, 9 to 10:30 a. m.; Moderator, Dr. A. Carlton Ernstene, Cleveland; Panel—Dr. John W. Martin, Cleveland, congestive heart failure; Dr. R. W. Scott, Cleveland, myocardial infarction; Dr. R. K. Bartholomew, Dayton, Cardiac arrhythmias.



K. C. McCARTHY, M. D.
Moderator, Course 2
"Office Anesthesia"

Course 2—"Office Anesthesia"; Wednesday, May 17, 9 to 10:30 a. m.; Moderator, Dr. K. C. McCarthy, Toledo; Panel—Dr. Alfred S. Gardiner, Cincinnati; Dr. F. W. Clement, Toledo; Dr. Roger L. Tecklenberg, Lima.



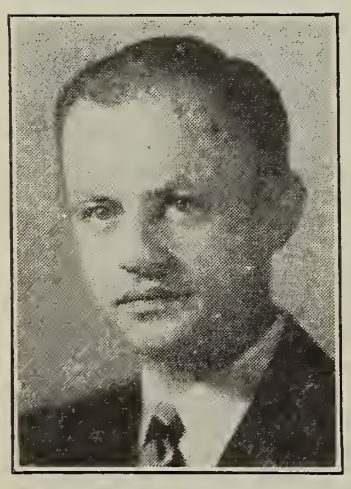
H. B. DAVIDSON, M. D.
Moderator, Course 3
"Blood Transfusions"

Course 3—"Blood Transfusions"; Wednesday, May 17, 9 to 10:30 a. m.; Moderator, Dr. Horace B. Davidson, Columbus; one of the panel of discussants will be Dr. Warren Wheeler of the Children's Hospital, Columbus; other panel members will be announced.



J. I. GOODMAN, M. D.
Moderator, Course 4
"The Use of Drugs in the Aged"

Course 4—"Drug Therapy in the Aged"; Wednesday, May 17; 9 to 10:30 a. m.; Moderator, Dr. Joseph I. Goodman, Cleveland; Panel—Dr. Siegfried Baumoel, Cleveland, cerebral and sedative drugs; Dr. Harold Feil, Cleveland, cardiovascular and pulmonary drugs; Dr. Reginald A. Shipley, Cleveland, endocrine and related medication.



A. C. BARNES, M. D.
Moderator, Course 5
"Diagnosis and Treatment of the Infertile Couple"

Course 5—"Diagnosis and Treatment of the Infertile Couple"; Wednesday, May 17, 9 to 10:30 a. m.; Moderator, Dr. Allan C. Barnes, Columbus; Panel to be announced.

Course 6—"Osteoporosis and Other Diseases of Bone"; Thursday, May 18, 9 to 10:30 a. m.; Moderator, Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, Columbus; Panel—(to be announced).

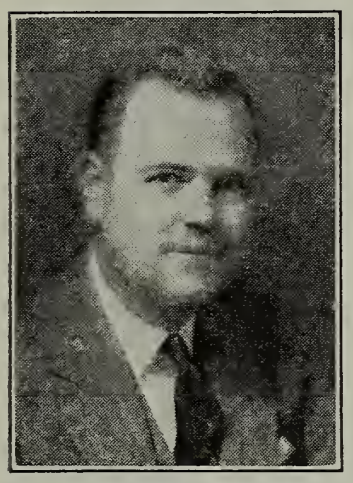


C. A. DOAN, M. D.
Moderator, Course 6
"Osteoporosis and Other Diseases of Bone"

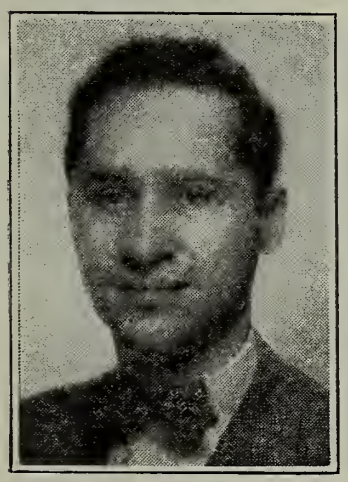
Course 7—"Poliomyelitis"; Thursday, May 18, 9 to 10:30 a. m.; Moderator, Dr. James G. Kramer, Akron; Panel—Dr. Alex J. Steigman,



J. G. KRAMER, M. D.
Moderator, Course 7
"Poliomyelitis"



C. F. McKHANN, M. D.
Moderator, Course 9
"Care of Newborn and Premature"



F. N. SILVERMAN, M. D.
Moderator, Course 11
"Pediatric Roentgenologic Diagnosis"



C. W. HARDING, M. D.
Moderator, Course 13
"Understanding and Treating the Alcoholic"

New York, National Foundation for Infantile Paralysis; Dr. Warren Wheeler, Children's Hospital, Columbus; Dr. Walter M. Solomon, Cleveland; Dr. Albert L. Bershon, Toledo.

Course 8—"Prolonged Labor"; Thursday, May 18, 9 to 10:30 a. m.; Moderator, Dr. Richard D. Bryant, Cincinnati; Panel—Dr. A. Hirsheimer, Dayton; Dr. N. E. Wentsler, Akron; Dr. Burdett Wylie, Lakewood; Dr.. Dean Sheldon, Sandusky.

Course 9—"Care of the Newborn and Premature"; Thursday, May 18, 9 to 10:30 a. m.; Moderator, Dr. Charles F. McKhann, director of pediatrics, University Hospitals of Cleveland. Panel to be announced.

Course 10—"Antibiotics"; Thursday, May 18, 9 to 10:30 a. m.; Moderator, Dr. Maurice A. Schnitker, Toledo; Panel—Dr. Charles F. Rammelkamp, Department of Preventive Medicine, Western Reserve University School of Medicine; Dr. Norman W. Thiessen, Lakewood; Dr. John E. Brown, Jr., Columbus.

Course 11—"Pediatric Roentgenologic Diagnosis"; Thursday, May 18, 10:30 a. m. to 12 m.; Moderator, Dr. Frederic N. Silverman, director, Department of Roentgenology, Children's Hospital, Cincinnati; Panel—Dr. Eugene Saenger, Cincinnati; Dr. James F. Martin, Cincinnati; Dr. W. H. R. Howard, Cincinnati; Dr. John Caffey, New York.

Course 12—"Injuries to the Chest"; Thursday, May 18, 10:30 a. m. to 12 m.; Moderator, Dr. Donald M. Glover; Panel—Dr. Edward Harlan Wilson, Columbus; Dr. William Falor, Akron; Dr. Vinton E. Siler, Cincinnati; Dr. Stanley Hoerr, Cleveland.

Course 13—"Understanding and Treating the Alcoholic"; Thursday, May 18, 10:30 a. m. to 12 m.; Moderator, Dr. Charles W. Harding, Columbus. Panel to be announced.

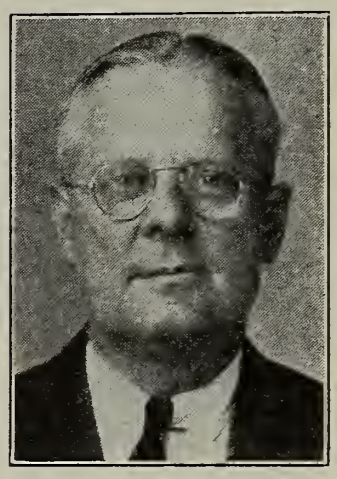
Course 14—"Emergencies in Eye, Ear, Nose and Throat"; Thursday, May 18, 10:30 a. m. to 12 m.; Moderator, Dr. Claude S. Perry, Columbus. Panel—Dr. Albert L. Brown, Cincinnati, Blunt trauma to eye (A) hemorrhage and Rx. (B) other changes; Dr. Charles I. Thomas, Cleveland, (1) Chemical burns and irritants, (2) corneal transplant, what it can and cannot do; William H. Evans, Youngstown, (1) hemorrhage of nose and throat, (2) emergency care of fracture of the nose; Dr. Daniel W. Brickley, Jr., Marion, (1) acute ear infections, middle and external, (2) foreign bodies in ear.



R. D. BRYANT, M. D.
Moderator, Course 8
"Prolonged Labor"



M. A. SCHNITKER, M. D.
Moderator, Course 10
"Antibiotics"



D. M. GLOVER, M. D.
Moderator, Course 12
"Injuries to the Chest, Abdomen and Spine"



C. S. PERRY, M. D.
Moderator, Course 14
"Emergencies in Eye, Ear, Nose and Throat"

Doctors, Educators Discuss School Health

Representatives of More than Fifty County Societies Spend Sunday In Columbus to Attend Unique Conference Sponsored by Association

INTEREST of the medical profession in school health was emphasized by a conference held in Columbus on February 5. Representatives of 50 County Medical Societies responded to an invitation of the Ohio State Medical Association and heard the subject discussed from various viewpoints by authorities in respective fields.

Dr. Carl A. Lincke, President of the Ohio State Medical Association, presided at the meeting and reviewed the medical professions interest and activities in the field of school health. In his introductory remarks, he brought out the fact that the American Medical Association has been working with the National Education Association for more than 30 years on the subject of school health.

Through the efforts of the Committee on School Health of the Ohio State Medical Association, headed by Dr. Thomas E. Shaffer, local committees on school health have been formed by three-fourths of the 88 county medical societies throughout the State, Dr. Lincke revealed. The Association's committee and local committees, he said, are working in harmony with the Ohio Department of Education, the Ohio Department of Health, the Ohio Congress of Parents and Teachers, the Farm Bureau, the Grange and other organizations which are vitally interested in school health.

The general theme of the discussion was "How Can We Work Together." Approximately 110 persons were present to hear the theme discussed by a panel of discussants and a representative of the A. M. A.

TYPICAL PROGRAM DESCRIBED

H. C. McCord, superintendent of Worthington Public Schools, described the school health program in effect in his schools. His is one of about 22 similar programs instituted six years ago under sponsorship of the Kellogg Foundation which operates through the Ohio Department of Education.

The program started with a class in health, under direction of an instructor who was given special refresher courses at Ohio State University. The program then broadened. Representatives of all organizations in the community were invited to offer suggestions on formulating policy. Policy is formulated by a group which includes the school principal, nurse, physical education teacher, elementary school principal, two physicians and a dentist. A card is kept on file for each student. Information on the card includes parents' instructions in case of accident or serious illness.

Mr. McCord emphasized the need of school-doctor cooperation on physical examinations of students and stated that he believed doctors should be compensated for their time in this work.

NEED DOCTORS' HELP

Dr. W. P. Cushman, associate professor of physical education at Ohio State University, discussed the subject of why the teacher needs the help of the physician. The teacher, he said, knows that as high as 20 per cent or more of youngsters will develop vision defects that will impair learning. Hearing defects also impair learning. The teacher should know if a pupil is an epileptic or a diabetic; whether he has had polio or rheumatic fever or suffers from some other handicap. When a child returns after an acute illness, the teacher should know if he is in condition to try to make up for lost time. Questions often come up, especially in health classes, Dr. Cushman, as to the status of limited practitioners, or the value of certain patent medicines. The teacher, he emphasized, needs advice from a doctor on many such questions.

P. T. A. PRESIDENT SPEAKS

Mrs. R. C. Bickel, Columbus, president of the Ohio Congress of Parents and Teachers, gave a general picture of what the Congress is doing in school health. In the field of health, she said, the Congress has six committees—one each on dental hygiene, health, mental hygiene, school lunch, social hygiene and summer roundup.

The summer roundup of preschool children in most communities, she said, is conducted by parents taking their children to the family doctor for a check up and for immunization. In some communities a clinic is held at the school to which parents bring their children.

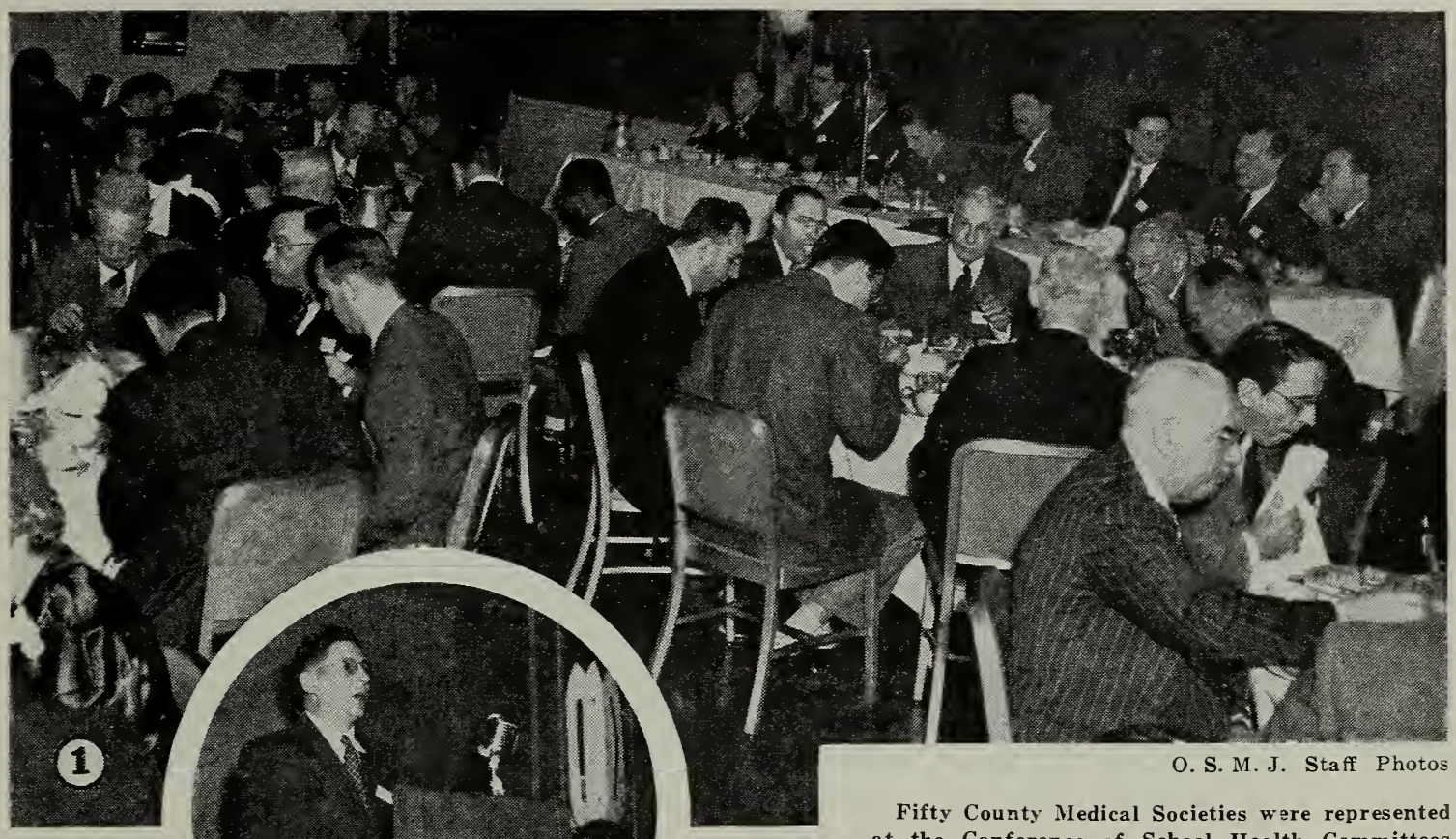
Another program of the Ohio Congress of Parents and Teachers is that of sponsoring health conferences in each of the nine districts of the State, through the Ohio Department of Healh..

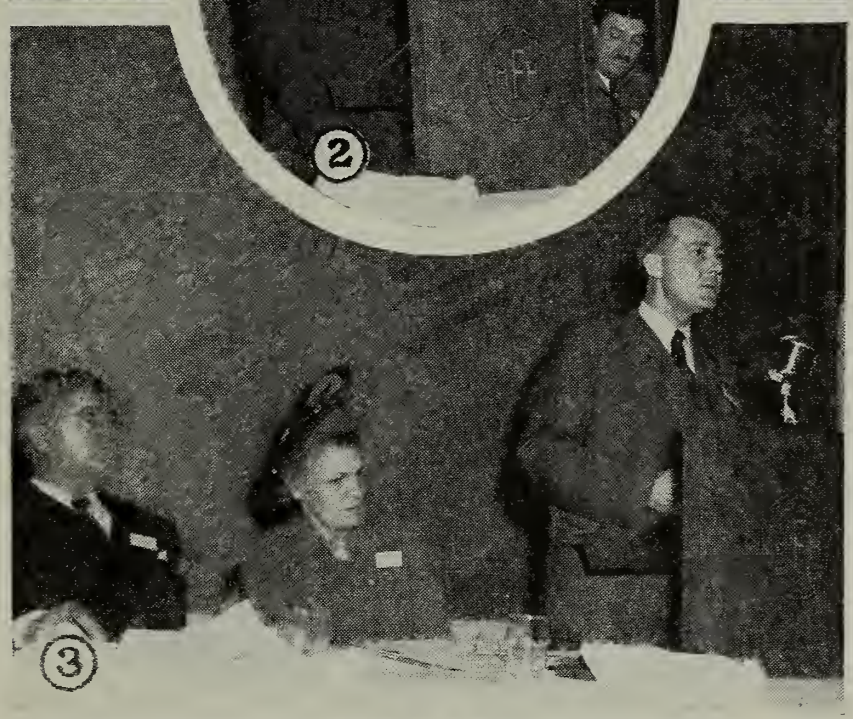
OHIO EDUCATION OFFICIAL

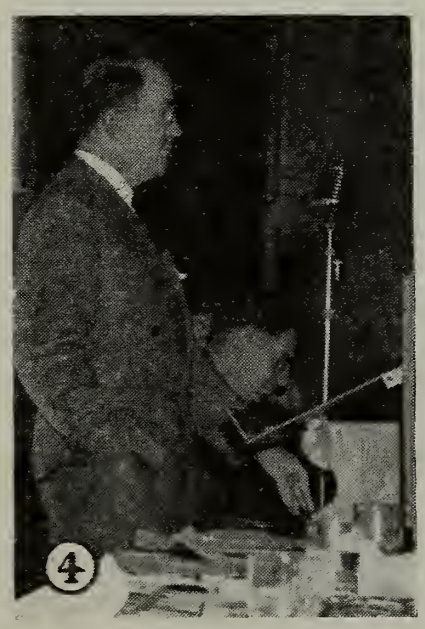
Paul E. Landis, supervisor of health, physical education, recreation, and safety, Ohio Department of Education, described the health programs in schools as provided by the Department of Education and local school boards. Mr. Landis pointed out that the medical profession must provide the technical and professional services

TO BE A GOOD CITIZEN, YOU MUST BE REGISTERED TO VOTE

School Health Committeemen Hear Problems Discussed









O. S. M. J. Staff Photos

Fifty County Medical Societies were represented at the Conference of School Health Committees of Ohio's County Medical Societies in Columbus on February 5 under sponsorship of the Ohio State Medical Association.

1. Part of the group of approximately 110 are shown as they enjoyed luncheon at the Hotel Fort Hayes before entering into a discussion of the general theme, "How Can We Work Together." At the speakers' table are six panel discussants, and the principal speaker of the afternoon. They are (left to right):

(a) W. P. Cushman, Worthington, associate professor of physical education, Ohio State University;

(b) Dr. John D. Porterfield, director of the Ohio Department of Health, Columbus;

(c) Paul E. Landis, supervisor of health, physical education, recreation and safety, Ohio State University;

(d) Mrs. R. C. Bickel, Columbus, president of the Ohio Congress of Parents and Teachers;

(e) Dr. Carl A. Lincke, Carrollton, President of the Ohio State Medical Association, Chairman of the Conference.

(f) Fred V. Hein, Ph. D., Chicago, consultant in health and fitness, Bureau of Health Education, American Medical Association.

(g) Dr. Thomas E. Shaffer, Columbus, chairman of the Committee on School Health of the Ohio State Medical Association; and

(h) H. C. McCord, superintendent of the Worthington Public Schools.

2. Dr. Hein is shown as he discussed health education on national and local levels.

3. This photograph shows Dr. Shaffer conducting a general discussion on school health problebs on the local level. Seated are Mr. Landis and Mrs. Bickel.

4. Mr. McCord gave a practical review of the school health program as it is working in Worthington Schools.

5. Dr. Cushman described school health as applied on the college level.

See article on facing page for more details.

in the administration of school health service programs.

The physician, he said, should know that the school health service includes the operation of those agents or agencies which aim to conserve, protect and improve the health of school children. Physicians can give suggestions for construction and provision of restroom or first aid room; they can give advice on facilities for drinking water and sewage and waste disposal; they can advise effective means of establishing health education programs.

STATE HEALTH DIRECTOR

Dr. John D. Porterfield, director of the Ohio Department of Health, explained the role of the Department and local health departments in school health programs. He explained how health officials, especially a health nurse, can act as liaison between school and family. He explained also how the health department acts as an inspection agency for school facilities. He also suggested that school health program and health detection centers might be more closely coordinated. He explained also the educational program of the health department in its relation to school health.

Dr. Thomas E. Shaffer, medical director of the University faculty, is chairman of the Committee on School Health of the Ohio State Medical Association. Dr. Shaffer discussed relationship between school health programs and physicians of the community and emphasized the need of cooperation on the part of doctors. Dr. Shaffer also exlained the functions of the Association's Committee on School Health and how it is attempting to stimulate organization of such committees in each county society. Approximately three-fourths of the county societies now have school health committees, he said.

Dr. HEIN OF A. M. A.

Fred V. Hein, Ph. D., Chicago, consultant in health and fitness, Bureau of Health Education of the American Medical Association, complimented the Ohio State Medical Association for instituting such a meeting, and said that to his knowledge it was he first of its type staged anywhere.

Dr. Hein explained the functions of his Bureau which is directed jointly by him and a doctor of medicine. The Bureau of Health Education attempts to bring together thinking of educators and doctors on the subject of school health. It goes into the various states and tries to stimulate and to help in the development and expansion of school hetalth programs.

The Bureau, he explained, is in position to offer practical and technical advice on the use of appliances such as germicidal lamps in classrooms, the use of certain testing apparatus in health examinations, and the like. The Bureau offers materials for extensive educational programs. One of its features is an unlimited number of prepared radio programs on school health and other phases of health which are loaned to county societies for arrangement with local stations.

The Conference was concluded with a "Clinic on Local School Health Activities," conducted by Dr. Shaffer. Questions from the floor were discussed by the panel of speakers.

In addition to school health committeemen of county societies, the following members of the Committee on School Health of the Ohio State Medical Association were present: Dr. Shaffer, Dr. Frank A. Holloren, Springfield; Dr. Margaret O'Neal, Zanesville; Dr. Charles F. Good, Cleveland; Dr. Roy E. Shell, Van Wert; Dr. Carl A. Wilzbach, Cincinnati; and Dr. T. L. Light, Dayton.

Members of The Council present were: Dr. Lincke; Dr. A. A. Brindley, Toledo, Past-President; Dr. H. T. Worstell, Columbus, Treasurer; Dr. D. W. Heusinkveld, Cincinnati, Councilor of the First District; Dr. Merrill D. Prugh, Dayton, Councilor, Second District; Dr. Fred W. Dixon, Cleveland, Councilor, Fifth District; Dr. Paul A. Davis, Akron, Councilor, Sixth District; Dr. J. P. McAfee, Portsmouth, Councilor, Ninth District; Dr. H. M. Clodfelter, Columbus, Councilor, Tenth District; Dr. J. S. Hattery, Mansfield, Councilor, Eleventh District. Messrs. Charles S. Nelson, Executive Secretary, George H. Saville and Gordon Moore, of the headquarters office also were present.

Since the end of World War II tuberculosis case finding has been pushed in an ever widening area, and at present about 10,000,000 persons a year are receiving X-ray examinations.—Metropolitan Life.

IF YOU'RE NOT REGISTERED TO VOTE, VISIT YOUR ELECTION BOARD

Notice of Discontinuance If Dues Are Not Paid

If you are receiving *The Journal* as a member of the Ohio State Medical Association and have not paid your 1950 dues, your name automatically will be dropped from the mailing list. That means that this is the last issue of *The Journal* you will receive until such time as your 1950 dues are forwarded through your county medical secretary. The Association's dues are payable in advance for the fiscal year January 1-December 31. If you have not paid your 1950 dues, please forward them immediately to your county society secretary.

First Hill-Burton Hospital Completed . . .

Three Other New Institutions To Be Opened in Near Future; More Than 37 Projects Now on Approved List; 22 Are Under Construction



Photo Courtesy The Wooster Daily Record

This is a view of the newly completed Wooster Community Hospital, scheduled to open with ceremonies on March 4.

FIRST of the hospital projects in Ohio constructed under the Hill-Burton Law will be officially opened when the Wooster Community Hospital is scheduled to be dedicated on March 4.

This is a general hospital and public health center with facilities for 70 beds and 21 bassinets. Total cost of the project has been estimated at $1,369,986.66 of which the Federal government furnished a third.

Other projects scheduled to be opened in the very near future are:

The Memorial Hospital of Fayette County, Washington Court House, with facilities for 34 beds, constructed at a cost of $630,000 of which the Federal government furnished one-third. This is a combination general hospital and health center.

Richland County Tuberculosis Sanitorium, Mansfield, an 84-bed sanitorium constructed at a cost of $788,025.58.

Mount Saint Mary Hospital, Nelsonville, general hospital and health center with 74 beds; total cost, $1,256,965.98 of which the Federal share was one-third.

Public Law 725, or the Hill-Burton Law, originally appropriated $75,000,000 of Federal funds as grants-in-aid for hospital construction. The amount has since been increased to $150,000,000.

Ohio became eligible for participation in the program as of the fiscal year July 1, 1947- June 30, 1948. Twenty-one projects were approved for participation under the first two years' appropriations. Nearly six million dollars in Federal funds are available to Ohio each year under the new appropriation through June of 1955.

NEW PROJECTS

Following are new projects in addition to the 21 previously approved, which have either complete or preliminary approval of the Surgeon General:

The Chronic Disease Hospital of Hamilton County, Cincinnati; 440 beds; construction cost, $4,695,528.27 (Federal share, $1,195,528,27).

The Cuyahoga County Chronic Disease Hospital; in conjunction with present Cuyahoga County Tuberculosis Hospital at Warrensville; 400 or more beds; cost $5,829,400 (Federal share, $829,400).

Williams County Hospital, Montpelier; 34 beds; cost, $550,000 (Federal share, $183,333.33).

Adams County Hospital, West Union; cost, $375,000 (Federal, $125,000).

Brown County Hospital, Georgetown; cost, $600,000 (Federal, $200,000).

Molly Stark Tuberculosis Sanitorium, Canton; cost, $750,000 (Federal, $250,000).

Marietta Hospital; 55-bed addition to present hospital; cost, $600,000 (Federal, $200,000).

St. Marys Hospital, St. Marys; 50 beds; $750,-000 (Federal, $250,000).

Alliance City Hospital; addition to present hospital; $1,575,000 (Federal share, $525,000).

Euclid-Glenville Hospital (suburban Cleveland); $3,000,000 (Federal, $1,000,000).

Lawrence County General Hospital, Ironton; $124,699.98 (Federal, $41,566.66).

Mercy Hospital, Portsmouth, $1,624.00 (Federal share on equipment only, $160,000).

Good Samaritan Hospital, Sandusky; addition

to existing hospital plus equipment; $771,000 (Federal, $257,000).

Dettmer Hospital, Piqua-Troy area; $1,700,000 (Federal, $497,109).

Morrow County Hospital, Mt. Gilead; equipment only, $93,000 (Federal, $31,000).

Springfield Mercy Hospital, equipment only, $329,302.56 (Federal, $109,767.52).

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since January 1, 1950. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ALLEN COUNTY
Charles L. Blumstein, Lima
Oliver A. Horak, Lima
Asa C. Jones, Jr., Lima
Howard C. Kingsbery, Lima
Harry Warshawsky, Lima

AUGLAIZE COUNTY
Robert J. Herman, Wapakoneta

BELMONT COUNTY
Robert N. Lewis, St. Clairsville

BROWN COUNTY
Kevin C. McGann, Georgetown

BUTLER COUNTY
Robert C. Dunn, Middletown
Betty B. Owens, Middletown
William I. Owens, Middletown

CLARK COUNTY
Max D. Graves, Springfield
Herman L. Guyselman, Springfield
Maurice Tatelman, Springfield

CLINTON COUNTY
Robert E. Suer, Wilmington

COLUMBIANA COUNTY
Joseph T. Noe, East Liverpool

COSHOCTON COUNTY
George D. Mogil, Coshocton

CRAWFORD COUNTY
Bernard M. Mansfield, Galion

CUYAHOGA COUNTY
Hugh R. Anderson, Lakewood
Joseph M. Black, Cleveland
Kent L. Brown, Cleveland
Arthur F. D'Alessandro, Cleveland
Earl S. Hallinger, Jr., Cleveland
Charles A. Hubay, Cleveland
Robert C. Kirk, Cleveland
William F. Kubicek, Jr., Cleveland
A. Engle Lenhert, Cleveland
Alan R. Moritz, Cleveland
Frank J. Rack, Cleveland
Charles E. Richards, Cleveland
Lewis A. Steinhilber, Cleveland
Joseph A. Votypka, Cleveland
Paul R. Zeit, Cleveland

DARKE COUNTY
Daryl M. Parker, Hollansburg

DELAWARE COUNTY
Robert A. Vogel, Delaware

ERIE COUNTY
John R. Mellen, Milan
Harold E. Snedden, Sandusky
Richard H. Williamson, Huron

FAIRFIELD COUNTY
Lloyd L. Kersell, Lancaster
Carl R. Reed, Lancaster
Floyd R. Town, Lancaster

FRANKLIN COUNTY
Alfred Adler, Columbus
A. Waite Bohne, Columbus
George T. Brooks, Columbus
C. Joseph Cross, Columbus
James K. DeVore, Columbus
Dorothy E. Eshbaugh, Columbus
John P. Garvin, Columbus
James R. Gay, Columbus
George R. Hoeflinger, Hilliards
Raymond L. Jennings, Westerville
Frank C. Long, Jr., Columbus
William O. McNellie, Columbus
W. Hugh Missildine, Columbus
Samuel W. Robinson, Columbus
John P. Smith. Columbus
Robert F. Sylvester, Jr., Columbus
Philip H. Welch, III, Columbus

FULTON COUNTY
Francis E. Elliott, Wauseon
Cal S. Kellogg, Swanton
Keith S. Wemmer, Delta

GALLIA COUNTY
James A. McMurrin, Gallipolis

GREENE COUNTY
Ernest Hoffman, Jr., Yellow Springs

HAMILTON COUNTY
John B. Chewning, Cincinnati
William T. Collins, Cincinnati
Philip R. Dobert, Cincinnati
Barbara Ann Hewell, Cincinnati
Charles A. Mangham, Cincinnati
Charles J. Miller, Cincinnati
Alvin Nathan, Cincinnati
John Joseph Phair, Cincinnati
William B. Rudemiller, Cincinnati
Arthur C. Utrecht, Cincinnati
Otto W. Wilton, Cincinnati
Jean Paul Wozencraft, Cincinnati
Joseph F. Wright, Cincinnati

HANCOCK COUNTY
R. Grant Janes, Findlay

HIGHLAND COUNTY
John R. McBride, Hillsboro
George L. Morris, Hillsboro

JACKSON COUNTY
Alvis R. Hambrick, Wellston

LAKE COUNTY
Anthony J. DiCello, Painesville

LUCAS COUNTY
Horace E. Allen, Toledo
Shoichi Asahina, Toledo
George S. Bova, Toledo
Robert G. Fish, Toledo
Frederick V. Gipson, Toledo
Donald Haselhuhn, Toledo
Leo B. Janis, Toledo
Felix B. Martin, Toledo
Jack W. Millis, Toledo
Anthony J. Regent, Toledo
Charles L. Stevers, Toledo
John J. Tansey, Toledo

MAHONING COUNTY
James A. Patrick, Youngstown

MARION COUNTY
William B. Leffler, Marion

MEDINA COUNTY
Carl J. Ferber, Valley City

MONTGOMERY COUNTY
Henry J. Caes, Dayton
Jesse P. Kuperman, Dayton
David B. Roth, Dayton
Harold J. Schneider, Dayton
Samuel P. Studybaker, Miamisburg
Nicholas J. Thompson, Dayton

PICKAWAY COUNTY
Warren R. Hoffman, Ashville

PORTAGE COUNTY
Walter W. Lang, Kent

SANDUSKY COUNTY
Donald C. Haugh, Fremont

SHELBY COUNTY
Richard H. Breece, Jackson Center
John H. Kerrigan, Sidney
George J. Schroer, Sidney

STARK COUNTY
Cyril V. Gross, Canton
John Dueber Joliet, Canton
Richard H. Kelty, Canton
William S. Rothermel, Canton

TRUMBULL COUNTY
Joseph A. Browning, Warren
Gene D. Fry, Girard
John A. Grima, Warren

UNION COUNTY
Malcolm MacIvor, Marysville

WASHINGTON COUNTY
William R. Stewart, Marietta

WAYNE COUNTY
Seymour C. Boor, Creston
Robert A. Davison, Shreve
Joel F. Pratt, Wooster

WOOD COUNTY
Floyd A. Nassif, Luckey

Course on General Surgery

"Practical Problems in General Surgery" is the subject of a continuation course to be presented on April 6, 7, and 8 by the Frank E. Bunts Institute and the Cleveland Clinic. On Friday evening, April 7, Dr. Daniel C. Elkin of Emory University, Dr. Claude Beck of Western Reserve University Medical School, and Dr. R. B. Turnbull of the Cleveland Clinic will take part in a symposium on "Vascular Surgery." On Saturday morning, April 8, Dr. George G. Finney of Johns Hopkins University and others will present Panel Discussions on surgery of the colon, pancreas, biliary tract, and stomach and duodenum.

Inquiries regarding the complete program and registration can be addressed to the Director of Education, Frank E. Bunts Educational Institute, 2020 East Ninety-third Street, Cleveland 6, Ohio.

ARE YOU REGISTERED TO VOTE?
IF NOT, ACT PROMPTLY

Columbus Blood Center Ranks High . . .

Local Red Cross Unit Ranks Fourth of Centers in Nation And Is Lower Than All Others in Cost Per Pint Furnished

THE Red Cross Blood Program is designed to bring the benefits of blood to everyone without charge. The Franklin County Regional Center, opened in Columbus December 7, 1948, was the 18th to be put into operation nationally. It now ranks fourth in the entire country in the collection of blood. As of December 31, 1949, this center was topped only by Los Angeles, Philadelphia, and Washington, D. C., in the order mentioned.

The average national cost, in the 33 regional Red Cross centers now operating, for recruiting, processing, and distributing blood, is $18.60 per pint. During the first six months of 1949, the costs through the Franklin County Center were $7.41 per pint—the lowest average in the nation. This center is the only regional Red Cross center in Ohio.

COLLECTIONS AND DELIVERIES BY COUNTIES AND INSTITUTIONS

Red Cross records, December 7, 1948, through December 31, 1949, show the following collection and distribution in pints of blood in 26 counties

County	Collections		Deliveries
Shelby	658		738.5
Miami—Troy	635	873	
Piqua	575	771	
	1,210		1,644
Richland	1,491		1,985.5
Delaware	810		407.5
Madison	376	* (no hospital)	
Pickaway	162	(no hospital)	
Champaign	362		266
Crawford—Bucyrus	466	390	
Crestline	229	122	
Galion	225	196	
	920		708
Ashland	509		267.5
Athens	678		287
Logan	821		304
Knox	556		850
Fairfield	1,005		566
Marion	1,149		1,197.5
Coshocton	602		395
Hardin	388		338
Licking	1,323		537
Ross	688		517
Fayette	265	(no hospital)	
Union	277	(no hospital)	
Perry (one visit)	67		32
Hocking	89		50
London Prison Farm	311		
Mansfield Reformatory	1,135		
Woman's Reformatory	52		
Ohio State Penitentiary	1,235		
Franklin County	8,240	**	13,176
TOTAL	25,379		24,298.5
		Other Regions	39
		TOTAL	24,337.5

* They may avail themselves of Red Cross blood in the hospital to which they are sent.
** 30 per cent of Franklin County distributions are made to out-of-town patients hospitalized in Columbus.

Heart Research Grant

Award of $60,961 in Public Health Service grants for four non-Federal heart research projects investigating hardening of the arteries, high blood pressure and the effect of chemical and electrical substances on the heart, has been announced. The grants were made by the National Heart Institute to three medical schools and a private foundation.

Part of the grant was awarded to the Cleveland Clinic Foundation, where Dr. Irvine H. Page will investigate endocrine glands to determine their role in the development of high blood pressure and hardening of the arteries.

Domus Medica

The Domus Medica, international center of medical welcoming organizations, occupies a new office at 111 East Oak St., Chicago. This organization has corresponding offices in the principal countries of the world. Physicians may write to the Domus Medica for information or for international contacts, as well as for scientific, cultural, artistic and tourist viewpoints. Physicians who plan to visit foreign countries are invited to contact Dr. Valentin Charry, delegate of Domus Medica, at the Chicago address.

Northern Tri-State To Meet In Grand Rapids, April 11

The Northern Tri-State Postgraduate Medical Association, which includes Indiana, Ohio and Michigan, will hold its 77th Annual Meeting in Grand Rapids, Mich., April 11. Further information may be obtained from Dr. James E. McMeel, secretary, 133 S. Main St., South Bend, Ind.

Speakers and their subjects for discussion include the following:

"The Present Therapy of the Commonest Skin Diseases"—Dr. A. P. R. James, director of the City Skin and Syphilis Clinics, Toledo.

"The Neurological Complications of Injury to the Head and their Treatment"—Dr. Paul C. Bucy, M. D., University of Illinois.

"The Place of Surgery in the Treatment of Peripheral Vascular Disease"—Dr. G. DeTakats, University of Illinois.

"Rupture of Bladder and Urethra," Etiology, Diagnosis and Treatment—Dr. Vincent J. O'Connor, Northwestern University Medical School.

"Pathological Conference"—Dr. F. Hartman and associates, Ford Hospital, Detroit.

"A Doctor Makes a Critical Survey of the Medical Profession"—Dr. Paul R. Hawley, newly appointed director of the American College of Surgeons.

"Pharmacologic Approach to the Treatment of Neurogenic Disorders"—Dr. Frederick F. Yonkman, Ciba Pharmaceutical Products Co.

"Methods for Diagnosing the Types of Anemias and the Choice of Medicines in their Treatment."—Dr. R. Isaacs, University of Michigan.

"The Management of the Diabetic Patient by the General Practitioner"—Dr. J. H. Warvel, Eli Lilly & Co.

"Anemias of Childhood, Plan for Diagnosis and Outline of Treatment"—Dr. J. L. Wilson, University of Michigan.

Average Physician Exempt Under New Wage-Hour Act

The average physician is not subject to the provisions of the new Federal Wage-Hour Act, calling for a minimum hourly wage of 75 cents for employees because he is not engaged in interstate commerce.

If a physician's practice would extend into another state, he also would probably be exempt under the provision which exempts employers and employees of any retail service establishment of which more than 50 per cent of the annual dollar volume of sales of goods or services are made within the same state.

Nurses and technicians employed by physicians would be automatically exempt, in any event, as they would be classified as professionals.

General Practice Chapter Elects

Dr. Dale E. Putnam, Westerville, is the 1950 president of the Franklin County Chapter of the American Academy of General Practice. Dr. Roger E. Heering, Columbus, was chosen president-elect and Dr. Florence Lenahan, Columbus, was elected secretary-treasurer.

Members of the Board of Trustees are: Drs. R. W. Bonnell, Anthony R. Marsicano, Thomas E. Rardin, Percy B. Wiltberger, Lovell W. Rohr, Alice M. Bustin, Oscar L. Coddington, John N. Cross, Joseph C. Forrester, John P. Urban, J. J. Hughes, Henry W. Karrer, Adolf W. Verhoff, Thomas P. Wangler and John W. Wilce, all of Columbus.

A. M. A. Dues Deductible

The $25 dues of the American Medical Association are deductible under the provisions of the Federal Income Tax Law as professional expense.

The A. M. A. has requested the U. S. Commissioner of Internal Revenue for an official ruling on whether the 1949 special assessment is deductible—a point on which there has been a difference of opinion.

Discontinue Pay For Drugs

The State Industrial Commission has announced that physicians and hospitals will no longer be reimbursed for the cost of penicillin and streptomycin administered to claimants. The reason given is that the cost of these antibiotics has decreased so materially that they can no longer be considered "expensive drugs." There is no change in the fee schedule for professional services.

Ohio Health Association To Meet in Columbus

The annual meeting of the Ohio Public Health Association will be held in Columbus, May 11-12. President of the organization is Dr. F. E. Mahla, Lucas County health commissioner. President-elect is Dr. Carl A. Wilzbach, Cincinnati health commissioner.

Among those appointed on the program committee are: Dr. Harry Wain, Richland County-Mansfield commissioner, Chairman; Dr. Ollie M. Goodloe, Columbus commissioner, and Dr. John D. Porterfield, director of the Ohio Department of Health.

Anyone engaged in or interested in public health may become a member by sending in his name, address, a note of special interest or field and the $2 annual dues to Roy Haines, secretary-treasurer, 15 Lawrence Block, Bellefontaine.

ARE YOU REGISTERED TO VOTE?
IF NOT, ACT PROMPTLY

Antihistaminic Drugs . . .

Food and Drug Administration Issues Memorandum Outlining Policy in Regard to Over-Counter Sale of Tablets to Public

A MEMORANDUM from the Washington office of the Federal Food and Drug Administration furnishes background on the release of antihistaminic drugs now being sold directly to laymen by drug stores. It also shows how the Food and Drug Administration deals with drug firms in the marketing of a new drug.

The memorandum was sent to the Ohio Department of Health from the Cincinnati District Offices of the Administration, under direction of Mr. K. L. Milstead. It is quoted herewith in full as it appeared in *Ohio's Health*, publication of the Ohio Department of Health.

* * *

STATEMENT RE ANTIHISTAMINIC DRUGS FOR LAY USE

New drug applications have recently been made effective for oral antihistaminic tablets for lay use. Additional new drug applications for similar products will be made effective in the near future. Not all of the firms have definitely decided to market their products and, in some cases, the proposed name may be changed before the drug is marketed.

The firms have been told that, in our opinion, the claims should be restricted to relief of symptoms of the common cold and of hay fever. The Administration's position is summarized in its letter of November 7, 1949, to the National Better Business Bureau, Inc., New York, New York.

NO PANACEA

"Answering the specific questions in your letter of October 28 which deals with antihistamine tablets, we certainly do not believe that anyone and everyone who takes one of these tablets at the first symptoms of a cold will have his cold stopped.

"We assume that you are in general familiar with the research which began some years ago and which resulted in the manufacture of a number of medicines which have in some cases the ability to counteract the effects of histamine.

"These drugs have until recently been restricted to sale on prescription. They have been conclusively shown to be very helpful in hay fever, certain types of sensitization rashes, and in several other conditions generally believed to be due to reactions to histamine release. On the other hand, for some unexplained reason, they appear to possess very limited value in conditions such as asthma which also are generally believed to be related at least in part to the release of histamine.

NUMBER OF INVESTIGATIONS

"More than a year ago a number of investigators expressed the view that the early symptoms of colds are allergic in origin. They believed that colds should be benefited by antihistamine therapy. Probably Dr. J. M. Brewster, medical officer in the United States Navy, is largely responsible for the present extensive interest in the use of antihistamine drugs for the prevention and treatment of the common cold.

"Publications dealing with clinical trials which he has made of a number of these products are to be found in the *U. S. Naval Bulletin* 47:811, 1947, and in the same publication 49:1, 1949. He was also author of an article which appeared in *Industrial Medicine*, 18:217, 1949. There are other published clinical investigations and we have also seen reports of clinical studies which have not as yet appeared in print.

"The net impression which these articles as a whole convey to our medical staff is that a number of investigators who may be regarded as competent to conduct controlled clinical studies have reached the conclusion that, in the case of many colds, if therapy with antihistamine drugs is begun immediately when the first symptoms appear the symptoms may be suppressed and for all practical purposes the cold aborted.

"Some investigators are so optimistic as to ascribe these benefits to some 80 per cent to 90 per cent of the persons treated. They practically all agree that the effectiveness of the medication decreases when the medication is not started early in the course of the cold.

AVAILABLE EVIDENCE

"The available scientific evidence at this time is that probably the antihistamine drugs have a legitimate place in cold therapy. We are very skeptical of the breadth of the claims which purveyors of the product wish to make in selling medications in this class to the lay public.

"Our skepticism arises first because a statistically sound clinical study of the effect of any medicine in the common cold is most difficult. This is further complicated when the medication must be taken at the first sign of a cold to manifest maximum results. It is common experience of all of us to believe that we can recognize the first symptoms of a cold.

"Many times we are wrong since after having undertaken no treatment whatsoever we just

do not develop a cold. Another factor that introduces uncertainty into the situation is that in spite of much research a precise definition of the common cold has never been forthcoming.

"Most authorities agree that the illness which the public refers to as the common cold is not a single disease. It probably involves a number of different diseases which manifest the same or similar symptoms. We do not believe that anyone at this time can say authoritatively whether or not the antihistamines will affect all of these disease entities.

ADVERTISING

"Your letter refers to advertising. You, of course, know that the Federal Trade Commission rather than ourselves is responsible for the enforcement of the statute which deals with advertising. When manufacturers have asked our advice concerning proposed labeling we have urged conservatism in claims for these new products and have sought to bring about a full disclosure of the sort of facts which we have discussed in this letter.

"We are not naive enough to believe that this advice will be followed literally. From a law enforcement standpoint the prospect of tremendous sales of these products with growing intense competition is quite likely to engender the broadest possible claims. Our responsibility will be to learn the precise facts and to ascertain them in such a way that they can be presented convincingly in a court of law.

"Unfortunately, evidence of this sort cannot be accumulated quickly and we regretfully conclude that there will be a substantial period of time before this situation can be adequately dealt with."

(Signed) A. E. Rayfield."

Canal Zone Needs Doctors

The Panama Canal needs civilian physicians for duty in the Canal Zone. This need has arisen because the Army is withdrawing a large number of commissioned medical officers who have been assigned to duty with the Panama Canal, according to an announcement from the Washington office of the Panama Canal.

Starting salaries range from $6,750 to $9,500. Transportation is provided appointee and family. Opportunity is open to gain experience in tropical country, with opportunity for specializing in several branches. Further information may be had from B. F. Burdick, Chief of Office, Panama Canal, Washington 25, D. C.

Poisons claim the lives of more than 2,000 persons a year, most of them children under five, according to *Ohio's Health.*

TO BE A GOOD CITIZEN, YOU MUST BE REGISTERED TO VOTE

Athens County Society Deplores Criticism of U. M. W. Fund

The following resolution was passed unanimously by the Athens County Medical Society at a meeting on January 10, 1950:

"Resolved: Inasmuch as it has come to our attention that severe criticism of the medical setup of the Welfare and Retirement Fund of the United Mine Workers of America has falsely and fraudulently been represented as having come from 'a spokesman for the medical profession' in the vicinity of Nelsonville, Ohio, be it hereby resolved that The Athens County Medical Society having jurisdiction in the territory mentioned hereby reaffirms the full approval previously given to the medical section of this Fund by our representative in the Council of the Ohio State Medical Association.

"Having worked with those in charge of the medical aspect of the administration of this Fund, we have been much impressed with the fairness and understanding shown by them and deplore the fact that this unfair and dishonest newspaper report was published."

New Health Education Discs Are Available

The A. M. A. Bureau of Health Education has produced a series of three new electrical transcriptions which are available free, on a loan basis, to state and county medical societies.

Your Child Goes To School" is a series of 13 programs based on unsettled and sometimes conflicting questions relating to the health of school children. The programs are summarized by D. A. Dukelow, M. D., and Fred V. Hein, Ph. D., the medical and educational consultants respectively for the Bureau of Health Education.

"The Living Proof" is a series of 13 tape-recorded experiences delivered in the voices and words of patients themselves together with interviews of the physicians under whose care these patients made progress toward recovery or learned to live with their affliction. This series is exceptionally high in human interest and dramatic impact. It is based upon a successful series developed and broadcast by the Chicago Industrial Health Council and in its original form received numerous radio awards. It has not been heard outside of Chicago, and the A. M. A. has exclusive rights outside of Chicago for the next four years.

"Doctors Make History" is a series of 13 dramatic narratives with music, each dealing with the life of an outstanding American physician who also was a distinguished citizen aside from his professional eminence.

The entire series was produced under the general supervision of Dr. W. W. Bauer and Harriet Hester.

Buckeye News Notes . . .

Ashtabula—Dr. Alfred A. DeCato succeeded Dr. Donald D. Forward as medical staff president at Ashtabula General Hospital.

Ashtabula—Dr. E. M. Wright of Coshocton spoke before the Ashtabula County Association of Life Underwriters on the theme that the infringement of private enterprise by the Federal government is just one step toward a socialistic state.

Ashtabula—Dr. C. E. Case was honored at an informal party upon having completed 45 years as local surgeon for the New York Central System. Top district officials of the Railroad were present.

Bowerston—Dr. Edward L. Miller has moved his practice to Dennison, His practice has been taken over by Dr. Carl Nicosia, formerly of Buffalo, N. Y.

Cincinnati—The Cincinnati Medical Women's Club, Branch 11, A. M. W. A. and the Cincinnati Women Lawyers held their third annual dinner meeting at the Cincinnati Club January 31, with Dr. Gustav Echstein as guest speaker.

Cleveland—Dr. Donald A. Kelley succeeded Dr. Edward M. H. Castle as physician for the Cleveland Indians.

Cleveland—Dr. Claude S. Beck headed the committee which made arrangements for the symposium on "Recent Advances in Cardiovascular Surgery" on Jan. 21 in Washington, sponsored by the Surgery Study Section of the National Institutes of Health of the Public Health Service.

Columbus—Dr. Charlotte Winnemore has been appointed medical director of the Columbus Regional Blood Center.

Columbus—Dr. Daniel J. Whitacre is the new chairman of the Northeast District Committee, Boy Scouts of America. The district includes Linden, Westerville and East Columbus.

Columbus—Dr. Margot Deckert, acting chief of the Division of Child Hygiene of the Ohio Department of Health since March, 1949, was elevated to the position of chief on January 1.

Columbus—Dr. Anthony J. Ruppersburg, Jr., was presented the Legion of Merit Award as the result of his service with the 37th Division of the Ohio National Guard. He was in command of the 71st Station Hospital in the Pacific during the war. He is now a Colonel and chief surgeon of the Ohio National Guard.

Covington—Dr. George A. Woodhouse of Pleasant Hill spoke to members of American Legion Post 80 on the subject, "Pending Legislation of Socialized Medicine."

Delaware—Dr. James G. Parker spoke before the St. Mary's P.-T. A. on the subject "Medical Problems of the School Child."

Fremont—Dr. J. C. Boyce spoke before the Fremont P.-T. A. on the subject of "Socialized Medicine."

Lakewood—Dr. C. Lee Graber, spoke on the subject of "Socialized Medicine" before the Lakewood Business and Professional Women's Club.

Lima—The Lima Rotary Club honored the memory of the late Dr. J. R. Tillotson for his work with crippled children by presentation of his portrait to the Lima Visiting Nurses Association.

Maholm—Dr. Carl L. Petersilge, Newark, spoke to the Maholm P.-T. A. on the subject, "Children's Health Problems."

Mansfield—Dr. F. J. Heringhaus spoke to the Optimist Club on the subject of heart disease.

Marietta—Dr. C. A. S. Williams was named to the city health board to succeed Dr. J. F. Weber.

Marietta—Dr. J. F. Weber is the new health commissioner of Washington County.

New Philadelphia—Dr. George Crile, Jr., Cleveland, was guest speaker at an open meeting of the Tuscarawas County Cancer Society.

Oak Hill—Dr. Brinton J. Allison was reelected for another term as Jackson County health commissioner.

Salem—Dr. Lea A. Cobbs was elected president of the Columbiana County Health League at its annual meeting.

Steubenville—Dr. Roy W. Scott, Cleveland, addressed the Fort Steuben Academy of Medicine.

Steubenville—Dr. Walter A. Cunningham addressed the Steubenville Junior Chamber of Commerce on the subject of socialized medicine.

Xenia—Dr. Paul F. McQuiggan addressed the Xenia Business and Professional Women's Club, stressing the position which American Medicine has achieved.

Zanesville—Dr. Herman B. Kaufman addressed the local Kiwanis Club on the subject, "Socialized Medicine."

Zanesville—Dr. Margaret O'Neal succeeded Dr. Beatrice T. Hagen as health commissioner of Muskingum County.

Medical Care in Small Communities Problem at National Conference

Constructive recommendations toward providing medical care to small communities came out of the fifth annual conference on Rural Health in Kansas City, Mo., February 3-4, at which the Ohio State Medical Association was ably represented.

The conference was sponsored by the Committee on Rural Health of the American Medical Association in cooperation with farm organizations, and was attended by more than 500 medical and lay leaders.

Among the recommendations for further progress were the following:

(1) Communities should make every effort to attract doctors by providing hospital or clinical facilities to enable them to keep abreast of the times and to make community life attractive to them and their families.

(2) Wider community participation in securing necessary facilities is a forward step which should be pushed with increasing vigor. This is a phase in which community health councils can play a leading role.

(3) Existing and proposed facilities should be coordinated and integrated for an effective and fully utilized program.

(4) An intensified educational program is needed to acquaint people with facilities available to them, with university extension services an important medium in this education.

(5) Communities must be stimulated to undertake more realistic and objective measurement of health and hospital needs, it having been pointed out that many of the hospitals built with Federal aid under the Hill-Burton Act were being used only to half capacity..

(6) Tax funds should be used to provide medical care only when it is impossible for an individual to secure such care without such help.

(7) Progress has been made in enrolling rural people in prepayment medical care plans but greater efforts should be made in that direction.

(8) Medical schools should screen applicants early to eliminate those unqualified to become doctors, should encourage rejectees to prepare for related professions, and should incorporate training in rural practice into the curriculum.

Dr. Ernest E. Irons, president of the A. M. A., sounded a keynote in the attitude of the conference toward local problems when he said that it is "no compliment to rural groups to assume that they cannot devise plans to meet their own problems." In the matter of medical planning, Dr. Irons added that rural communities, "know what they want and need better than any bureau in Washington."

Dr. Carll S. Mundy, Toledo, attended in a dual capacity as vice-chairman of the Council on Rural Health of the A. M. A. and as chairman of the Committee on Rural Health of the Ohio State Medical Association. Other members of the State Committee who attended are: Dr. Jonathan Forman, Columbus; Dr. J. Martin Byers, Greenfield; Dr. E. G. Caskey, Mineral Ridge. Mr. Hart F. Page of the Headquarters Office and secretary of the Committee on Rural Health, also attended.

Medical History Group Offers Program April 15

All those who are interested in medical history are most cordially invited to attend the tenth annual meeting of the Committee on Medical History and Archives of the Ohio Archaeological and Historical Society, at the Ohio State Museum, Columbus, on April 15, beginning at 9 a. m. Presiding at the meeting will be Dr. Jonathan Forman, chairman of the Committee and lecturer in medical history at Ohio State University.

Included in the program are the following features:

"Samuel Hanbury Smith of Cincinnati, Columbus and Hamilton," Dorothy M. Schullian, curator of rare books, Cleveland Branch, U. S. Army Medical Library, Cleveland.

"Ohio Physicians of the Nineteenth Century, a Statistical Study," Frederick C. Waite, Ph. D., Dover, N. H.; emeritus professor of histology and embryology, Western Reserve University.

"The Development of Dermatology in Ohio," Leon Goldman, M. D., professor of dermatology, University of Cincinnati.

"The Development of Hygiene and Health Museums," with notes on the Western Museum in Cincinnati and the part that Daniel Drake had in it, Bruno Gebhard, M. D., director of the Cleveland Health Museum.

"Body Snatching in Ohio During the Nineteenth Century," Linden Edwards, professor of anatomy in the Ohio State University.

"James Salisbury, M. D.," Clyde Cummer, M. D., assistant clinical professor of dermatology, Western Reserve University.

"Notes on Early Development in Roentgenology," Otto Glasser, physicist, Cleveland Clinic.

"Historical Items Related to Ohio in Army Medical Museum," Thomas Haviland, chief of operations, Museums of the U. S. Army Medical Corps, Washington, D. C.

"The Medical Aspects of the Miami-Erie Canal," Louis R. Effler, M. D., Toledo.

At present, only one state (Arizona) has a tuberculosis death rate of over 60 per 100,000 population. In 1933, when nationwide figures first became available, 19 states and the District of Columbia had rates of 60 or higher.—Metropolitan Life.

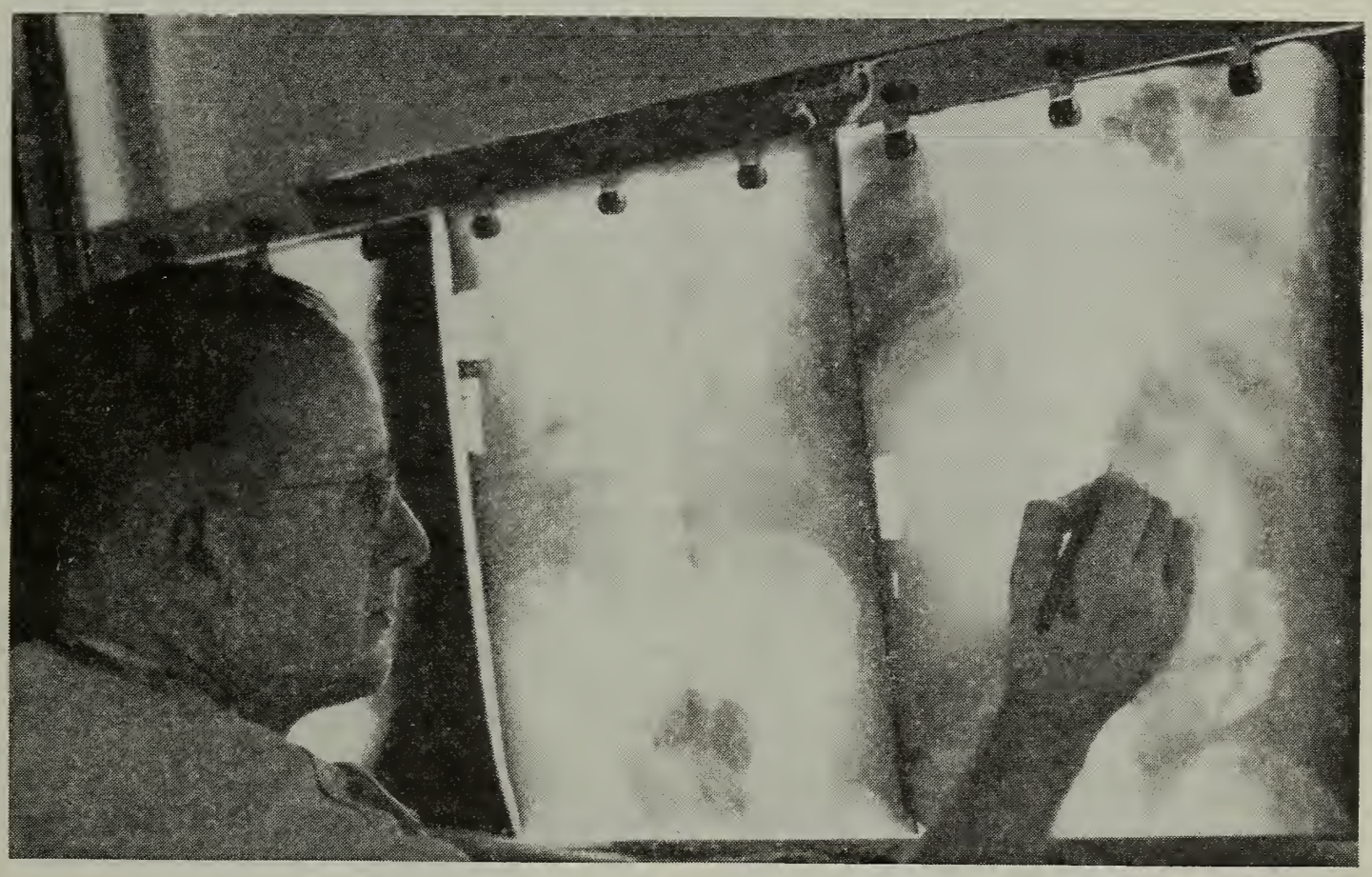
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RESEARCH IN THE SERVICE OF MEDICINE

Parrot Fever . . .

With Mild Outbreak of Psittacosis in Northeast Section of State, Ohio Public Health Official Issues Warning and Reviews Etiology

RECENT isolation of virus from psittacine birds and the occurrence of one proven and several suspect cases of psittacosis in humans have made it necessary for the Ohio Department of Health to issue a warning of the possible dangers of infection.

One flock known to have been infected was in a pet shop in Canton. Before the flock was inspected many birds had been sold to persons throughout the state without records of transactions. The proven case of psittacosis in a human was that of a man in Steubenville who said he purchased a bird from the Canton shop.

Warnings were issued to persons who recently have purchased birds of the advisability of consulting veterinarians if birds become ill and their family physicians if illness occurs in families.

Because of possibility of infection and the fact that psittacosis is relatively uncommon and easily confused with atypical pneumonia, Dr. Charles R. Freeble, Jr., chief of the Division of Communicable Diseases of the Ohio Department of Health, prepared the following review for *The Journal.*

SYMPTOMS REVIEWED

Psittacosis, or more correctly ornithosis since it occurs in orders of the aves class other than the psittacine, is a specific infectious disease which is transmissable to man. It is due to a filterable virus which has been isolated from the nasal secretions, blood, liver, and spleen of birds and from nasal secretions and lung tissue of humans. The disease is highly communicable from bird to bird and somewhat less so from bird to man. There is some evidence that the disease is air borne, and that the portal of entry is the upper respiratory tract.

Experimental observations indicate that the incubation period is between eight and fourteen days. Onset in man is abrupt and accompanied by chilly sensations, headache, backache, and fever. Cough is usually absent or nonproductive at first, but later is present and productive of extremely viscous light yellow sputum. At the height of the infection there is marked prostration, restlessness and occasionally delerium. Epistaxis occurs in about 25 per cent of the cases. The temperature is quite high and remains so for a period of a week or more, then declines by lysis. Pulse is usually slow in relation to the temperature. Albuminuria is almost constant and the white blood count is normal or slightly increased with a moderate leukopenia developing later.

The disease may be transmitted to mice by intraperitoneal innoculation of blood drawn during the first week of illness and causes characteristic pathologic changes. Sputum is more uniformly infectious than the blood, but repeated trials are often necessary. The serum of recovered cases contains complement-fixing antibodies.

Patients who show a high temperature, slow pulse, headache, indefinite pneumonic signs without pleural pain, absence of leucocytosis, and give history of recent association with psittacine birds should be suspected and have their sputum tested by the mouse test for psittacosis. Additional aid is to be derived from complement-fixation tests on acute and convalescent specimens of the patients' serum.

Isolation of patients is required during the acute febrile stages and strict adherence to medical aseptic technique is strongly advised. Concurrent and terminal disinfection should be practiced and suspect birds sacrificed and examined. Contacts should be kept under surveillance for a period of fourteen days, but placarding is not practiced. Cases should be reported to local health authorities in order that the infection may be traced and necessary precautions taken to prevent further spread to humans or other bird flocks.

Prognosis is guarded, with experience showing a fatality rate of 30-40 per cent in diagnosed human cases. Experimentally, high doses of penicillin have been found to be effective against the infection, as has aureomycin, but extensive clinical reports on their use in human psittacosis have not been published.

ARE YOU AND MEMBERS OF YOUR FAMILY REGISTERED TO VOTE?

Dr. Papanicolaou To Direct Course In Exfoliative Cytology

A course in Exfoliative Cytology for physicians will be given under direction of Dr. George N. Papanicolaou at Cornell University April 17-29. Inquiries may be directed to Dr. Papanicolaou at Cornell University Medical College, 13 York Ave., New York 21.

A similar course will be given for laboratory technicians March 20-April 1, also under direction of Dr. Papanicolaou. Inquiries about the technicians' course should be directed to Miss Charlotte M. Street at the above address.

Dr. John D. Porterfield, director of the Ohio Department of Health, announced that the Department will underwrite the expenses of any Ohio physician or technician accepted by the school for the course.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WHAT ARE YOU DOING ABOUT IT, DOCTOR?

What did you think of the recent "policy" statement issued by the Republican National Committee? It was pretty fuzzy and indefinite, in our opinion. Although protesting state socialism in any form, including socialized medicine, the statement contained an awful lot of "me too" applesauce on the matter of Federal handouts.

One commentator, after reading it, observed that Norman Thomas, the perennial Socialist candidate for President, once remarked that the American people would never vote for Socialism as such, but that Socialism was inevitable because their representatives in Congress would continue to vote for individual measures which, in the long run, would add up to Socialism.

Another writer offered the thought-provoking comment that the Republicans are promising "liberty" as against "socialism"; the Democrats cash money, from the public treasury, for special groups.

Now comes the announcement from the White House that President Truman plans to invade Ohio this year to take the stump for candidates who favor his hand-out, state socialism program.

A recent Gallup poll indicated that a large proportion of the people are not well informed about the compulsory sickness insurance issue. Only 54 per cent of those questioned could name at least one argument for or against the plan and only 30 per cent knew how the cost would be met.

Rather confusing, isn't it? Looks as if those who believe 1950 is the year of great decision have a job cut out for them. Cash money from the treasury is going to win the race unless the job of enlightening the voters is stepped up considerably between now and next November 7.

What are you doing about it, Doctor?

TALK-IT-OVER SESSIONS WITH THE DRUGGISTS

Editor John W. McPherrin has reprinted many of the editorials which appeared in *The American Druggist* in an attractive book entitled "Where We Stand." The collection of 62 editorials reflects beyond any question that the druggists in this country see no good whatsoever in the government practice of medicine.

"If the patients, doctors and druggists of our metropolitan areas could know each other better, we don't think there would be any more support for government control of health in the big cities than in the small towns," said one editorial, adding: "Such a situation is difficult to achieve but it has been done in the small neighborhood communities of some of our largest cities. When druggists and doctors express friendly confidence in each other, they help create faith in private medicine."

In our opinion, Mr. McPherrin's advice is sound and timely. Talk-it-over sessions for doctors and druggists should become a custom in every community. Try it in your county.

FACTS, FIGURES AND FALLACIES

Ohio State Chiropractic Society announces that it will circulate petitions to initiate a bill for a separate licensing board at the 1951 session of the State Legislature . . . giving as its reason the deep desire of chiropractors to police their own profession . . . presumably the habitual law violators, most of whom can't pass present exams or never even try.

* * *

Congressman Biemiller, Wisconsin's gift to the ranks of the socializers, had Milton Mayer's critical article of questionable authenticity about the A. M. A., "The Dogged Retreat of the Doctors," which appeared in *Harper's Magazine*, inserted in the appendix of the Congressional Record at a cost to the taxpayers of $410 . . . another indication of how free some public officials are with other people's money.

* * *

One economist, using Bureau of Labor Statistics figures, has shown that the 1949 dollar was worth not quite 46 cents compared with its value in 1939 in terms of what it will buy . . . which explains why the present-day working man scolds his wife because she can't make both ends meet on $40 a week whereas $20, ten years ago used to do the job.

* * *

Commenting on Oscar Ewing's remark before the National Press Club that he fails to see any obligation to feed doctors who would refuse to join his health insurance scheme, George Dixon, Washington columnist, opined: "Why does any American listen to Ewing and his kind? Can't the simplest intelligence understand he can't have the government running his body without having it running his life?"

* * *

Branding current Social Security "saving" for the future as a "fiction," the Brookings Institution predicts that the costs of present and proposed security expansion schemes would cost the nation $55 billion annually in another 50

years . . . In 1949, approximately 341,000 Ohioans received Federal Social Security benefits of various kinds, exclusive of general welfare, health and educational services partially financed from U. S. funds for all Ohio citizens.

* * *

A. P. story says a renewal of the 10-cent tax on union members for the A.F.L.'s separate political education fund is being considered . . . Wasn't it Mr. William Green of the A. F. L. who bitterly denounced the A. M. A. for raising a public education campaign fund?

* * *

During December, 295 local advisory councils of the Ohio Farm Bureau discussed the question of improved health and medical services in rural areas . . . All took a definite stand against compulsory health insurance, pointing out that there are sound ways of solving the health problems of rural Ohio if the people will pull together.

* * *

Average age at death of the 3,331 physicians whose obituaries were published in *The Journal of the A. M. A.* in 1948 was 67.2 years. . . . heart disease was the leading cause of death, 41 per cent . . . largest number of deaths occurred between ages 70 and 74.

* * *

F. B. I. agents who started checking the files of the Chicago office of the A. M. A. last October are still at it, using the Board of Trustees' room as their workshop.

* * *

Membership of the A. M. A. on January 1, 1950, was 144,212, a net gain of 4,171 during 1949 . . . gain in Fellows was 2,548 . . . Speaking of the A. M. A., a few doctors protest paying 1950 A. M. A. dues because they think they were not levied in a democratic manner . . .Provision for levying of dues has been in the A. M. A. Constitution and By-Laws for years, but never used . . . Action was taken by House of Delegates composed of physician-delegates elected by houses of delegates of the state societies, in turn composed of delegates elected by the county medical societies . . . Wherein was this procedure a violation of democratic principles?

* * *

According to one weekly news magazine, many psychiatrists are disturbed because Dr. Carl A. L. Binger, testifying in the Hiss trial, made an official diagnosis of Whittaker Chambers without interviewing him . . . They undoubtedly are correct in their belief that practices like this will discredit psychiatric testimony . . . in fact medical testimony generally.

* * *

This month's prize for under-statement goes to Truman's Council of Economic Advisers. . . In estimating that the cost 25 years hence of Truman's welfare schemes will be $25 billion, it blandly stated: "This is a very large figure."

MR. CHRISTENSEN PAYS HIS "DUES"

As a morale builder to those who may have some doubts as to why the American Medical Association needs to carry on an aggressive public education campaign, as well as an active intra-professional service program, and needs funds for both, we recommend careful reading of the following letter received recently by Dr. Ernest E. Irons, president of the A. M. A., from Mr. Joseph Christensen, Chicago, restaurant owner:

> "I cannot put M. D. after my name but I can, at least for a while, still put U. S. A. As a consequence, please accept the enclosed check for $25 as a slight token of regard for my doctor and all his colleagues. These are my 'dues' as a citizen, and I hope they will help in your fight against socialized medicine.
>
> "A people without guts are soon a nation without guts, and if it should become necessary to remove any part of mine, I want to pick my man and pay his charge without a precinct captain getting his nose in my anatomy."

STUDY OF METHODS OF TEACHING MEDICINE

Action by the Commonwealth Fund in granting $400,000 to Western Reserve University School of Medicine for a five-year experimental study of revisions in the methods of teaching medicine could become one of the most significant undertakings of the present decade. A real experiment of this kind is long overdue.

All of the problems confronting our medical schools are not financial problems. Reappraisal of curriculum and methods is imperative. Closer cooperation and a better understanding between medical educators and educators in charge of premedical training are needed.

The public is more interested in medical education today than ever before. For that reason it is confused, to put it mildly, as a result of the verbal warfare being waged between groups which have a part in educating doctors and all of which, presumably, have one objective, namely, the production of an adequate number of adequately trained physicians.

It's high time for a truce during which brains and energy can be devoted to a real attempt to find solutions. Readjustments within might even produce solutions to the financial problem which is one of major proportions.

It is heartening to know that private philanthropy has stepped forward with funds to do a basic job of this kind. There still may be hope that the financial problems of the medical schools can be met in the same manner.

Strangely enough, most of the causes for the

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present financial predicament of most of the medical colleges are results of the unsound economic policies instigated by a paternalistic government which now is eager to rush to their rescue. Medical schools would be in a better position to obtain endowments from private sources, if the government were to spend less and reduce taxes, thus giving private agencies and individuals an opportunity to continue with a job they have been doing for many decades.

AMVET COLUMNIST WARNS HIS BUDDIES

One of the best editorials we've seen on compulsory health insurance appeared in the January issue of *The Ohio AMVET*, monthly publication of the Ohio Unit of the American Veterans of World War II. Captioned "Farewell to Freedom," it was written by Fred J. Milligan, Columbus attorney, former State Commander of the AMVETS. His column "Post Scripts" is one of the features of the publication.

Mr. Milligan not only made a clear statement of the issue and the arguments against it, but he urged veterans to do something about it. After pointing out that the AMVETS went on record against the scheme at their National Convention last August, he stated:

"So far so good. But now is the time for every veteran to take his stand and make his voice heard through his local post to his congressman and senator. Furthermore, this is an election year and if we veterans have convictions on this subject it's our duty to see that no candidate for congress is permitted to straddle this important issue."

Realizing that the ramifications of the proposal go away beyond the socialization of medicine, Mr. Milligan continues:

"The adoption of the proposed compulsory health insurance program means a farewell to freedom as you fought for it. It means a 'Serf State.' A most valuable attribute of freedom is the right to choose—your associates, your home, your job freedom to determine the course of your life, and to live it as you choose so long as you do not infringe upon the rights of others. That is what you fought for. That is what has made the nation superior to any other—the supremacy of the individual because he is an individual. This freedom is guaranteed to all and can be taken away only if we actively consent or inactively permit ourselves to be lulled into bondage under the false guise of greater 'security.'"

As an alternative to "political medicine," Mr. Milligan suggests:

"Let us expand our hospital facilities.

"Let us increase our medical colleges.

"Let us admit more young people to the medical profession.

"Let us have more general practitioners. We need more 'family' doctors.

"All of this can be done without violence to anyone. The people will retain their freedom and self respect. They will receive more medical care at less expense. They will be free to choose their own doctors. They will be free to live their own lives in their own way. That is the only way to achieve happiness for the greatest number of people. And that is the true objective of government."

And Mr. Milligan knows something about government, for he formerly was assistant attorney general and later Director of Commerce for the State of Ohio.

INDUSTRIAL FUMES SHOULD BE CONCERN OF DOCTORS

The U. S. Public Health Service in the fall came out with a full report of the Donora (Pa.) incident in which industrial fumes stabilized by weather conditions caused the illness of thousands of persons, many of whom died.

Although acknowledging that a parallel situation might never again arise, the report states "that contamination of air in industrial areas can cause serious acute disabling diseases."

Since Ohio is one of the leading states in industry—much of which is concentrated—the report should be of particular interest to the medical profession here.

Although extensive studies of air pollution around industrial areas in Ohio have been made, undoubtedly even more extensive surveys will be conducted in the future.

Members of the medical profession should be prepared to offer any constructive aid and cooperation if or when such studies come up.

ARE YOU AND MEMBERS OF YOUR FAMILY REGISTERED TO VOTE?

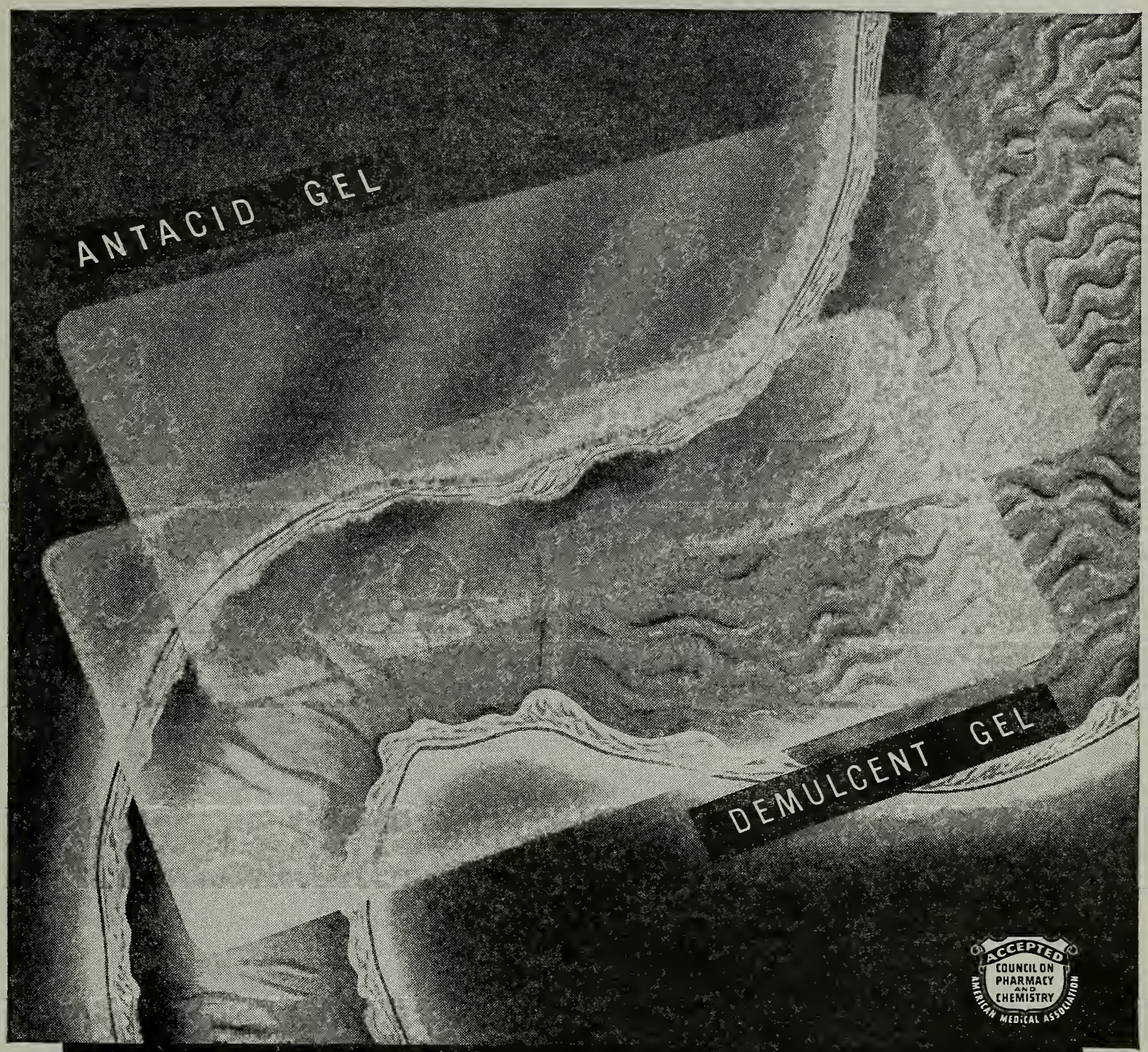
PUBLIC HEALTH IS RECOGNIZED AS A SPECIALTY

Public health workers can take a great deal of pride for their part in the achievements of the first half of the twentieth century, especially in the field of preventive medicine. Doctors in this field also can take pride in the growing recognition of their offices as key positions in the community.

Creation of the American Board of Preventive Medicine and Public Health, although coming at a time when further specialization is under some controversy, sets a milestone in the advance toward better and more progressive public health service.

Public health efforts have been hampered by the fact that the limited finances allotted by states, counties and municipalities often do not offer inducements commensurate with the responsibilities involved.

Creation of the new board should do much to convince legislators that health officers can be, and many are, authorities in their field and, when they are qualified, deserve remuneration in keeping with that of others with parallel responsibilities.



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Do You Know? . . .

Dr. Bruce K. Wiseman, professor of medicine, Ohio State University College of Medicine, Columbus, spoke on "Use of Radioactive Isotopes in the Treatment of Disease," during the annual Midwinter Clinics of the Colorado State Medical Society, Feb. 21-24 at Denver.

* * *

The death rate for accidents in the United States was 67.1 deaths per 100,000 population in 1948, compared with 69.4 in 1947.

* * *

The Environmental Investigations Branch of the Division of Industrial Hygiene of the U. S. Public Health Service is moving to Cincinnati, where it will be located in the Environmental Health Center of the Public Health Service. The policy of the U. S. P. H. S. is to concentrate in Cincinnati all its research on water, sewage and other sanitation problems.

* * *

A gift of $750,000 has been received by Northwestern University to establish the Irving S. Cutter Memorial Professorship in the School of Medicine. The donor, an alumnus of the School, wishes to be anonymous.

* * *

Dr. Robert M. Zollinger, professor of surgery, Ohio State University College of Medicine, was one of the guest speakers at the annual assembly of the American Academy of General Practice, Feb. 20-24, in St. Louis.

* * *

The Clark County Medical Society recently adopted a resolution in tribute to Dr. D. W. Hogue, Springfield, and presented him with a pair of binoculars on the occasion of his retirement after 50 years in the active practice of medicine. Dr. Hogue was Councilor for the Second District of the Ohio State Medical Association from 1935 through 1942. His new address is Rye, N. Y.

* * *

About 1,580,000 couples embarked upon matrimony in the United States in 1949, according to the statisticians of the Metropolitan Life Insurance Company. This is a decline of one-eighth from 1948 and nearly one-third less than the all-time peak of 2,291,000 marriages in 1946.

* * *

Dr. Joseph L. Fetterman, Cleveland, was guest speaker at a meeting of the Polk County Medical Society, Des Moines, Iowa, Feb. 15. He spoke on "A Survey of Psychiatry for the Practitioner With Particular Reference to the Use of Shock Therapy."

* * *

Enrollment in Ohio Medical Indemnity, "The Doctors' Plan" is now approximately 700,000 persons.

Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, spoke on "Doctors and Politics" at the Second Annual National Educational Campaign Conference of the American Medical Association, held at Chicago, Feb. 12.

* * *

An example of achievement in efforts to combine health districts for more efficient administration is that of the recently organized Crawford-Wyandot district. Dr. Guy T. Wasson, for many years health commissioner of Crawford County now directs the new district.

* * *

Dr. Robert M. Hall, newly appointed secretary of the A. M. A. Council on National Emergency Medical Service, is enlisting the help of secretaries of state medical societies in gathering important information pertaining to Civil Defense plans or programs in their areas.

* * *

Ohio State University's College of Medicine may be the first in the Nation to use color television in its instruction program. Permanent installations for the latest in television are being built into the new medical center building now nearing completion.

* * *

An example of additions to the State's hospital facilities is that of the Mercy Hospital in Springfield which opened recently. Addition of this 319-bed modern structure, built at a cost of $5,100,000, gives Springfield two modern hospitals.

* * *

Dr. A. Ashley Weech, medical director of the Children's Hospital, Cincinnati, in January went to Puerto Rico at the request of Puerto Rican physicians to deliver a series of 12 lectures on problems of child health.

* * *

Dr. Morris G. Carmody, Painesville, in January spoke before the Medical Advisory Committee to the Atomic Energy Commission in Cambridge, Mass. He is a member of the Committee. Dr. Carmody spoke on "Chronic Pulmonary Granulomatosis."

* * *

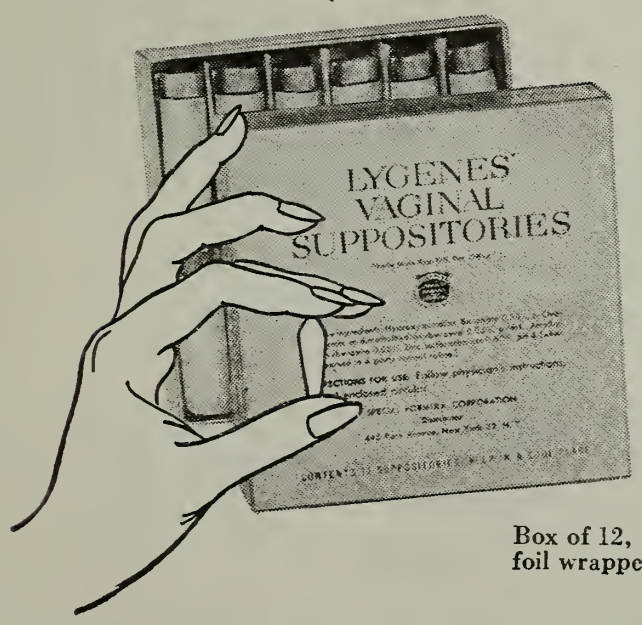
Dr. Raymond Hussey, Dean of the School of Occupational Health, Wayne University, Detroit, has joined the staff of the Council on Industrial Health of the A. M. A. as Scientific Director. In order to take the position, Dr. Hussey has relinquished his membership on the Council. He has been a member since 1941, serving as vice-chairman for the past several years.

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1. Eastman, N. J., Dept. of Obstetrics, Johns Hopkins University and Hospital, Baltimore, & Seibels, R.E., Memorial Laboratory, Columbia, S. C., J.A.M.A., 139:16-19 (Jan. 1) 1949.

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Shots at Truman-Ewing Compulsory Sickness Insurance Scheme; Ammunition For Doctors in Speeches Against Federalized Medicine

". . . English doctors buy their practice. Therefore, a doctor sells his practice when he reaches retirement age, and lives on the proceeds when he is too old to work. Physicians were forced to join the compulsory health service because, if they didn't, the government would not allow them to sell their practice."—*Dr. Elizabeth Everard, formerly of Bournemouth, England, now in Kingston, Ontario, Canada, interviewed by the Sidney (O.) Daily News, regarding England's health scheme.*

* * *

"This device (The Welfare State), by taxes, transfers to government, various social functions which the individual has taken upon himself. For instance, the United States actually possesses the best hospital system in the world, most of it voluntary, and supported by private charity. But charity must be measured not only against earnings but against taxes. As the ability to give charity is reduced, the voluntary institutions become increasingly dependent upon the state which can support them only by increasing taxes. But a tax is not an instrument of civilization and does the giver no good. He has no freedom of choice. In fact, as he pays more taxes, he becomes himself more dependent. In the end, he can become a slave."—*George E. Sokolsky.*

* * *

" . . . It is my considered opinion that the British program has resulted in more medical care of a lower quality for more people at a higher cost."—*Harold E. Stassen, President, University of Pennsylvania, in Reader's Digest, January, 1950.*

* * *

"Until some of the major defects of the Act are remedied, grave and unnecessary dangers will exist for both mother and infant . . . certain very definite risks to childbirth have been added by the present medical service."—*Review of first year's working of National Health Service of Great Britain, in The Practitioner.*

* * *

"The large majority of American families have the resources to pay for adequate medical care if they elect to give it a high priority among the several objects of expenditure."—*Report of the Brookings Institution on Medical Care for the Individual.*

". . . The introduction of the general dental service has indirectly caused the irreparable damage to the teeth of hundreds of thousands of school children . . ."—*Review of first year's working of the National Health Service of Great Britain, in The Practitioner.*

* * *

"Why does any American listen to Ewing and his kind? Can't the simplest intelligence understand he can't have the government running his body without having it running his life?"—*George Dixon in the Columbus Dispatch.*

* * *

"Do we have in America any movement comparable to the Fabian Socialist movement in England? And if so, what is it doing, how is it progressing and what are its chances of success here? The answer, of course, is that we do have precisely such a movement here, that it is making rapid strides, and that unless it is arrested, and at some very early date, nothing can prevent its extension here on the British model."—*John T. Flynn in The Road Ahead.*

* * *

"I understand that the Medical Fraternity in the United States are somewhat anxious concerning the possibility of the introduction of a Health Insurance Scheme on lines similar to our own. I give you fair warning that if this measure is adopted, they are likely to be faced with problems that will have a very adverse effect on the welfare of the country."—*Letter to Dr. D. W. Hogue from a London business man.*

ARE YOU AND MEMBERS OF YOUR FAMILY REGISTERED TO VOTE?

"It is a further fact that during the first year of the operation of the British National Health Service, from July, 1948, to July, 1949, the death rate in Britain went up rather sharply! . . . the additional tombstones in the British cemeteries—72,125 more than in the year before the National Health Program went into effect—are grim signposts on which we can read 'Never take this road for a National Health Program.' "—*Harold E. Stassen, President, Universty of Pennsylvania, in Reader's Digest, January, 1950.*

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In Memoriam . . .

Thomas Adams, M. D., Cleveland; Medical Faculty of Trinity University, Toronto, 1901; aged 73; died Nov. 17; member of the Ohio State Medical Association and the American Medical Association.

Francis Wayland Davis, M. D., Cincinnati; Miami Medical College, Cincinnati, 1891; aged 82; died February 4; former member of the Ohio State Medical Association and the American Medical Association through 1933.

P. William Haake, M. D., New York; Syracuse University College of Medicine, 1927; aged 50; died January 11; former member of the Ohio State Medical Association through 1941 and later a member of the New York State Medical Association; Fellow of the American Medical Association. Dr. Haake practiced in Zanesville until about 10 years ago when he left for New York. Surviving are his widow and two children.

William Edward Lawhead, M. D., Van Wert; Indiana Medical College, School of Medicine of Purdue University, Indianapolis, 1907; aged 63; died December 3; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Van Wert County Medical Society, 1943-45; delegate, 1943. Dr. Lawhead, retired medical officer of the U. S. Navy, accepted the position as city and county health commissioner last fall. Surviving are his widow and his father.

William Franklin Lehr, M. D., Arlington (Hancock County); Eclectic Medical College, Cincinnati, 1899; aged 79; died January 13; former member of the Ohio State Medical Association and the American Medical Association through 1947. Dr. Lehr had practiced in his community for more than 50 years. He was honored by the Hancock County Medical Society in November by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. He was a director of the Farmers and Merchants Bank in Arlington and was honorary president of the Hancock County Chorus. He had been both a member and president of the Arlington School Board, and was affiliated with the Odd Fellows and the Masons. Three children survive.

Eugene Phillips Neitz, M. D., Wellsville; Ohio State University College of Homeopathic Medicine, 1915; aged 59; died February 7; member of the Ohio State Medical Association and the American Medical Association; vice-president of the Columbiana County Medical Society in 1943. Dr. Neitz served in the Army Medical Corps during World War I. He practiced medicine in Cleveland, Youngstown, Petersburgh and Irondale before moving to Wellsville in 1933. He was a member of the city council for a year and was Wellsville's health commissioner for several years. Organizations in which he held memberships included the Masonic Lodge, the Elks Lodge, the American Legion and the Presbyterian Church. Surviving are his widow, a daughter, two sons and two brothers.

Norman William Neptune, M. D., Loudonville; Jefferson Medical College of Philadelphia, 1903; aged 80; died January 16; former member of the Ohio State Medical Association and Fellow of the American Medical Association through 1946; delegate of the Ashland County Medical Society in 1928. Dr. Neptune began his practice in Loudonville in 1903. He was a member of the Masonic Lodge and an officer in the Baptist Church. A son, Dr. Edgar M. Neptune of Syracuse, N. Y., survives.

Eugene Olin Porter, M. D., Cincinnati; Miami Medical College, Cincinnati, 1908; aged 75; died February 5; former member of the Ohio State Medical Association and the American Medical Association through 1948. Dr. Porter served his entire practice in Cincinnati and vicinity, where he was surgeon for the B. & O. Railroad until two years ago. He was affiliated with the Masonic Lodge. Surviving are his widow and a sister.

Clifton Reedy, M. D., Columbus; Starling Medical College, Columbus, 1897; aged 80; died January 29. Dr. Reedy retired from active practice in 1915. Surviving are his widow and two grandchildren.

Frederick George Stueber, M. D., Lima; Rush Medical College, University of Chicago, 1882; aged 89; former member of the Ohio State Medical Association and the American Medical Association through 1942; member of the American Academy of Ophthalmology and Oto-Laryngology. Dr. Stueber served most of his practice of nearly 60 years in Lima. Recently he was presented the Ohio State Medical Association's 50-Year Pin and Certificate. He was a member of the Triologic Society, was a charter member of the Board of Trustees of the Lima City Hospital and Memorial Hospital. He was an elder in the Evangelical and Reformed Church and served as a trustee of the church's Children's Home in Fort Wayne. Surviving are a daughter and a son, Dr. Paul J. Stueber, of Lima; also a grandson, Dr. Paul J. Stueber, Jr., of Cleveland.



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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

HAMILTON

Guest speaker at the Jan. 17 meeting of the Academy of Medicine of Cincinnati was Dr. Herrman L. Blumgart, Harvard University Medical School and physician-in-chief, Beth Israel Hospital, Boston, who spoke on the subject, "The Pathogenesis of Angina Pectoris." Dr. William T. Collins spoke briefly, giving a progress report on the operation of the Cytologic (Papanicolau) Laboratory at the Cincinnati General Hospital.

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

DARKE

"Anterior Poliomyelitis" was the topic of a discussion by Dr. Bert C. Wiley, Dayton, at the Jan. 17 meeting of the Darke County Medical Society.

MIAMI

Fifty-Year Pins and Certificates of the Ohio State Medical Association were presented to five Miami County physicians at the semi-annual meeting of the Miami County and Shelby County Medical Societies at the Piqua Country Club on Jan. 5. Those honored were Dr. George E. McCullough, Troy; Dr. Albert J. Bausman, Piqua; Dr. Charles Baker, West Milton; Dr. E. A. Yates, formerly of Piqua but now of St. Petersburg, Fla.; and Dr. James R. Caywood of Piqua. The award was presented posthumously to Dr. H. R. Pearson, late of West Milton.

Dr. M. D. Prugh, Dayton, Councilor of the Second District of the Ohio State Medical Association, made the presentations. Dr. E. O. Swartz, Cincinnati, President-Elect of the Ohio State Medical Association, was principal speaker for the occasion and spoke on "The Doctor Looks at Public Relations."

At the Feb. 3 meeting of the Miami Society, Dr. Charles R. Freeble, Jr., chief of the Division of Communicable Diseases of the Ohio Department of Public Health, Columbus, spoke on the subject, "A Discussion of Intensive Treatment Methods in the Treatment of Syphilis." This was a report of the work at the Rapid Treatment Center in Columbus.

The Society is sponsoring a new series of radio health broadcasts over Radio Station WPTW, Piqua, on Saturdays at 10:30 a. m., entitled "The Public Comes First." The following are topics of weekly programs: "What Constitutes Adequate Medical Care"; "Prepaid Medical Service Plans"; "Hospital Insurance and How To Make Use of It"; "What Are Rural Medical Problems"; "The Cost of Illness"; and "The Public Comes First."

SHELBY

Dr. Russell L. Wiessinger is the new president of the Shelby County Medical Society. Other officers are Dr. C. B. Conover, vice-pres., and Dr. John H. Kerrigan, secy.-treas. Delegate and alternate are Dr. Harry E. Grimm and Dr. V. W. LeMaster, respectively. All are of Sidney.

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Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D., UPPER SANDUSKY)

MARION

Delegate and alternate, respectively, of the Marion County Academy of Medicine are Dr. Alton E. Morrison, Marion, and Dr. Robert T. Gray, Prospect.

SENECA

Four veteran physicians of the county were honored on Jan. 11 at a meeting of the Seneca County Medical Society by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. They are Dr. Robert C. Chamberlain, Dr. William H. Benner and Dr. George W. Willard, all of Tiffin, and Dr. H. L. Hinkley of Green Springs. Dr. Chamberlain was not able to be present because he is in California on an extended visit. Presentations were made by Dr. J. Craig Bowman, Upper Sandusky, Councilor of the Third District.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

DEFIANCE

The monthly meeting of the Defiance County Medical Society was held at the Crosby Grill on Jan. 17. The following officers were installed: Dr. Harold J. Wenzinger, pres.; Dr. John U. Fauster, Sr., pres.-elect, and Dr. G. Frederick Moench, secy.-treas.; delegate, Dr. D. J. Slosser; alternate, Dr. Paul B. Newcomb.

A request by the Ohio Society for Crippled Children for approval of the traveling clinics in Defiance County for epileptics was granted by vote.

At a dinner meeting at the Kettering Country Club in Defiance on Feb. 14, four physicians were honored with the Fifty-Year Pin and Certificate of the Ohio State Medical Association. They are Dr. John U. Fauster, Sr., Dr. Seth DeMuth, Dr. S. J. Hull and Dr. R. W. Finch. Presentations

were made by Dr. Carll S. Mundy, Toledo, Councilor of the Fourth District of the Ohio State Medical Association.

LUCAS

Eighteen Lucas County doctors were honored by The Academy of Medicine of Toledo and Lucas County on Jan. 6 at its annual meeting, at which 50-Year Pins and Certificates of the Ohio State Medical Association were presented. They are: Drs. Ralph P. Daniells, R. V. Mateer, Louis A. Miller, E. W. Doherty P. Bruce Brockway, Christian Storz, Charles Lukens, H. L. Green, W. W. Alderdyce, Charles Louy, Paul E. Bethards, George M. Reinhart, George H. Jones, A. J. Richie, Burt G. Chollett, J. A. Coleman and Charles A. Burritt. In addition to the honor bestowed by the Association and the Toledo Academy, the *Toledo Blade* devoted three pages in its pictorial supplement of Jan. 1 to them.

Dr. Carll S. Mundy, Councilor of the Fourth District of the Ohio State Medical Association, made the presentations. In congratulating the physicians for their long and faithful service, Dr. Mundy reviewed the role of free medicine in the progress of the past half century. Dr. Brockway responded in behalf of the 50-year doctors.

Dr. Eugene A. Ockuly, incoming president of the Academy, gave the principal address of the evening. His talk was a plea for unification of medical organization effort in the Toledo area.

PAULDING

Dr. R. H. Mouser, Paulding, has been designated delegate and Dr. G. L. Doster, Paulding, alternate, for the Paulding County Medical Society.

SANDUSKY

Delegate and alternate, respectively, of the Sandusky County Medical Society are Dr. John J. Gedert, Clyde, and Dr. Edward B. Vogel, Bellevue.

WOOD

Dr. N. P. Dallis, Toledo, addressed the Wood County Medical Society on "Psychiatry in General Practice" at the regular dinner meeting at the Midway Restaurant, Perrysburg, January 19.

It has been a number of years since the Society program has included a paper on psychiatry and it was warmly welcomed. Dr. Dallis gave a discussion of the many classifications of mental disease covering organic disease, the psychoses, childhood manifestations of mental aberration, manic depressive types, involutional classes, paronoid states, melancholia, postpartum psychoses, anxiety neurosis and the paretic, the psychopath, the epileptic, the bromide patient and many others. Dr. Dallis gave an account of the malpractice hazards existing in this sector of medicine which was enlightening and of great

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1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

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value. Treatment such as can be used by the general practitioner and also a discussion of "shock" methods was described in detail as were the indications for institutionalization of the mental patient.

After a generous answering of questions with suggestions of textbooks, the members gave a rising vote of thanks to Dr. Dallis.

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

ASHTABULA

The monthly meeting of the Ashtabula County Medical Society was held at the Ashtabula Hotel following a dinner on Jan. 10. Dr. Fred A. Dixon, Cleveland, Councilor of the Fifth District of the Ohio State Medical Association, was first speaker of the evening and gave a review of medicine from the early days to the present in Ohio.

Dr. Lowry M. Guilinger, born 1869, a graduate of Chicago Homeopathic, 1898, and licensed in 1899; and Dr. Clarence E. Case, born 1870, a graduate of Western Reserve in 1895 and licensed in 1896, were presented Fifty-Year Pins and Certificates of the Ohio State Medical Association. Dr. Case spoke of his father who had been a physician before him and of the early hardships of physicians.

The Pin and Certificate for Dr. Melvin B. Todd, born 1866, a graduate of Cleveland University of Medicine & Surgery in 1894, and licensed in 1896, were forwarded in his absence. The Pin and Certificate for the late Dr. Lawrence A. Connell, deceased Sept. 23, 1949, were sent to his widow.

The Society decided to urge members to support Senator Robert Taft in his reelection. Along the line of combatting socialized medicine, members were urged to publicly take a more active part and a most definite stand regarding friendly and unfriendly politicians and legislation.

Guest speaker for the evening was Dr. Ralph Bacon, Erie, Pa. He gave an outline of what doctors in Pennsylvania are doing to acquaint the public with the cancer problem. He suggested further education of the public regarding the early symptoms of cancer. Announcement was made that the annual formal dance would be held at Hotel Ashtabula on Feb. 25.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

MAHONING

With the start of 1950, Dr. Gordon G. Nelson assumed office as president of the Mahoning County Medical Society. The new president-elect is Dr. Elmer J. Wenaas, who was named to the position at the Dec. 20 meeting, Dr. G. E. DeCicco is the new secretary, and Dr. L. H. Getty was reelected treasurer.

Dr. Vernon L. Goodwin, retiring secretary, was elected to a three-year term as delegate to the Ohio State Medical Association. The other two delegates whose terms are still in force are: Dr. William M. Skipp and Dr. Ivan C. Smith. Alternate delegates for one year terms are: Dr. Robert E. Odom, Dr. J. Clair Vance and Dr. Carl A. Gustafson. Dr. H. E. Patrick was reelected as the Society's representative on the board of directors of the Associated Hospital Service.

It was reported that the Mahoning Medical Service Foundation was ready to function and that the Mahoning County Commissioners were to arrange for payment for services of hospitalized cases.

At the Jan. 17 meeting, Dr. George Crile, Jr., Cleveland, spoke on "Some Problems in the Treatment of Peptic Ulcer." The Society is now meeting at the Elks Club.

Dr. William M. Skipp, delegate of the Ohio State Medical Association to the A. M. A., reported on actions taken at the December meeting of the A. M. A. in Washington.

SUMMIT

"Socialized Medicine" was the subject of a talk by Dr. James L. Doenges of Anderson, Ind., at the Jan. 3 meeting of the Summit County Medical Society. Members of the dental, nursing and pharmaceutical professions were guests of the Society at the meeting.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

Five physicians were presented 50-Year Pins and Certificates of the Ohio State Medical Association at the Feb. 16 meeting of the Belmont County Medical Society at the Belmont Hills Country Club. They are Dr. D. O. Sheppard, Barnesville; Dr. R. H. Wilson, Martins Ferry; Dr. E. W. Turner, Belmont; Dr. Henry F. Zink, Bellaire; and Dr. Homer S. West, St. Clairsville. Dr. R. J. Foster, New Philadelphia, Councilor of the Seventh District of the O. S. M. A., made the presentations. Scientific speaker for the occasion was Dr. Edward V. Turner of Columbus, who discussed phases of pediatrics.

HARRISON

Two Cadiz physicians, Dr. Anna B. Watson and Dr. John S. Campbell, were honored by being presented 50-Year Pins and Certificates of the Ohio State Medical Association. Dr. R. J. Foster,

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New Philadelphia, Councilor of the Seventh District of the Association, made the presentations. Dr. Campbell began his practice in Cadiz in 1889. Dr. Watson was a medical missionary in Egypt for the United Presbyterian Church for 15 years. She was active in practice until 1946.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M. D., LANCASTER)

FAIRFIELD

Officers of the Fairfield County Medical Society for 1950 are: Dr. Wilford D. Nusbaum, pres.; Dr. Victor N. Kistler, vice-pres.; and Dr. Arthur B. Van Gundy, secy.-treas., all of Lancaster. Delegate and alternate, respectively, are Dr. L. E. Stenger, Lancaster, and Dr. William M. Kuntz, Millersport.

Representative Walter E. Brehm, Logan, Eleventh Congressional District, was guest speaker at a meeting of the December meeting of the Fairfield County Medical Society in Hotel Lancaster. His subject was "Effects Socialized Medicine Would Have in the United States."

GUERNSEY

The regular meeting of the Guernsey County Medical Society was held at noon on Jan. 19 at the Berwick Hotel with 11 members present. Dr. Reo M. Swan, president, presided. Dr. Thomas S. Tonnous, Pleasant City, was in charge of the program.

Dr. Thomas W. Frame introduced the speaker of the day, Dr. James H. McCreary, Ohio State University College of Medicine, Columbus, whose subject was "Disseminated Lupus Erythematosis." While a rather rare condition, it was the speaker's opinion that the condition apparently is being seen more frequently in recent years. The speaker showed kodachrome pictures of typical cases of the three subdivisions—acute, subacute and chronic discoid types. A question-and-answer period followed.

Dr. Henry L. Wells spoke briefly on Board of Health matters, and suggested that all complaints to the Board of Health be submitted in writing. Dr. M. C. McCuskey suggested that members be on the alert for prospects to take over the newly created office of public health physician for Cambridge and Guernsey County. It was announced that the Society's Public Relations Committee would meet soon with County Commissioners to draw up a new contract for the care of indigent cases.

LICKING

Licking County Medical Society officers for the current year are Dr. James B. Johnson, Jr., pres.; Dr. Charles S. Bishop, vice-pres.; and Dr. R. Gilbert Mannino, secy.-treas. Dr. George A. Gressle is delegate and Dr. Johnson, alternate. All are of Newark.

MORGAN

Officers and representatives of the Morgan County Medical Society for the year are: Dr. C. E. Northrup, McConnelsville, pres.; Dr. E. G. Rex, McConnelsville, secy.-treas.; Dr. Henry Bachman, Malta, delegate; and Dr. A. A. Coulson, McConnelsville, alternate.

WASHINGTON

Dr. Clarence E. Ash of Beverly was elected president of the Washington County Medical Society for the year. Other officers and representatives are the following Marietta physicians: Dr. Kenneth E. Bennett, vice-pres.; Dr. William R. Stewart, secy.-treas.; Dr. Donald S. Williams, delegate, and Dr. Roy M. Meredith, alternate.

ARE YOU REGISTERED TO VOTE?
IF NOT, ACT PROMPTLY

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

The Lawrence County Medical Society will be host to the Ninth District at a meeting to be held at the Lawrence County General Hospital, Ironton, on Thursday, April 27. The scientific program will be in charge of a team selected by the Committee on Cancer of the Ohio State Medical Association. The subject of the present status of medical public relations will be given a prominent place on the program.

HOCKING

Dr. J. Ward Doering, Logan, was reelected president of the Hocking County Medical Society. Other officers are Dr. C. T. Grattidge, Laurelville, vice-pres., and Dr. Owen F. Yaw, Logan, secy.-treas. Delegate and alternate, respectively, are Dr. Grattidge and Dr. H. M. Boocks, Logan.

JACKSON

Officers of the Jackson County Medical Society for 1950 are the following: Dr. David S. Mack, Jackson, pres.; Dr. William T. Washam, Jackson, vice-pres., and Dr. Alvis R. Hambrick, Wellston, secy.-treas. Dr. John L. Frazer and Dr. Earl J. Levine, both of Jackson, are delegate and alternate, respectively.

LAWRENCE

Six Lawrence County doctors were presented the Ohio State Medical Association's 50-Year Pins and Certificates at a meeting of the Lawrence County Medical Society on Jan. 25 in Ironton. Dr. J. P. McAfee, Portsmouth, Councilor of the Ninth District of the Ohio State Medical Association, made the presentations to the following: Dr. William F. Marting, Dr. Daniel J. Webster, and Dr. Oliver U. O'Neil of Ironton; Dr. F. D. Campbell of Coal Grove; Dr.

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MEIGS

The Meigs County Medical Society, at its annual meeting on Jan. 26, presented the Ohio State Medical Association's 50-Year Pins and Certificates to five physicians. Dr. S. J. Blazewicz, president, made the presentations. Those who received the awards are: Dr. L. G. Gribble, Dr. W. S. Hart and Dr. S. S. Mart of Pomeroy, Dr. Wilbur Ellis of Middleport and Dr. John Philson of Racine.

Officers for the present year are: Dr. Joseph J. Davis, Middleport, president; Dr. Charles J. Mullen, Pomeroy, vice-pres., and Dr. William J. Jeric, Pomeroy, secy.-treas. Members voted to officially recognized the recently organized Woman's Auxiliary.

SCIOTO

At the Jan. 9 meeting of the Hempstead Academy of Medicine, Dr. Joseph P. Webb and Dr. S. Werthammer of Huntington, W. Va., discussed "The Liver-Needle-Biopsy and Its Use in Diagnosis of Hepatic Disease."

Tenth District

(COUNCILOR: H. M. CLODFELTER, M. D., COLUMBUS)

FAYETTE

Dr. Joseph M. Herbert is the new president of the Fayette County Medical Society for the ensuing year. Dr. E. H. McDonald is vice-pres., and Dr. Newton M. Reiff, secy.-treas. Dr. J. E. Rose is delegate and Dr. J. H. Persinger, alternate. All are of Washington Court House.

FRANKLIN

Officers of the Columbus Academy of Medicine who took office on Jan. 1 are Dr. Grant O. Graves, president; Dr. E. T. Kirkendall, pres.-elect, both of Columbus; and Dr. Oscar W. Jepsen, Canal Winchester, secy.-treas.

Members of the Council, in addition to the officers, are: Drs. Gilman D. Kirk, Rollo W. Bonnell, John M. Lowery, John M. Thomas, James H. McCreary, Robert E. S. Young, Warren G. Harding, Horace B. Davidson, Jack S. Silberstein, Allan C. Barnes, Frank A. Riebel, Clark P. Pritchett and Thomas E. Rardin.

Trustees are Drs. Rollo W. Bonnell, Harrison S. Evans, Thomas E. Rardin and John E. Brown, Jr.

Delegates are Drs. Charles W. Pavey, Franklin C. Hugenberger, Phillip T. Knies, Richard L. Meiling, Gilman D. Kirk and Robert E. S. Young.

Alternates are Drs. Anthony Ruppersberg, Jr., George F. Collins, William L. Pritchard, Clark P. Pritchett, Reuben B. Hoover and Thomas E. Rardin.

Speaker for the Jan. 16 meeting of the Columbus Academy of Medicine was Dr. Max M. Zinninger, University of Cincinnati College of Medicine, whose subject was "The Diagnosis and Management of Acute Intra-Abdominal Conditions."

KNOX

Members of the Knox County Medical Society elected the following officers and representatives to serve during 1950: Dr. Robert H. Hoecker, Mt. Vernon, pres.; Dr. Joseph W. Allman, Centerburg, vice-pres.; Dr. Charles E. Cassaday, Mt. Vernon, secy.-treas.; Dr. Henry T. Lapp, Utica, delegate; and Dr. Raymond S. Lord, Fredericktown, alternate.

MORROW

Dr. Lowell Murphy, Cardington, was reelected president of the Morrow County Medical Society for 1950; Other officers are Dr. William Deffinger, Marengo, vice-pres., and Dr. Francis W. Kubbs, secy.-treas. Delegate and alternate are Dr. J. P. Ingmire and Dr. C. S. Jackson, both of Mt. Gilead.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

ASHLAND

Dr. William F. Emery was guest of honor at the Ladies Night meeting of the Ashland



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County Medical Society in early January, at which meeting he was presented the 50-Year Pin and Certificate of the Ohio State Medical Association. Dr. C. B. Meuser, colleague of Dr. Emery's for 38 years, made the presentation. Dr. George M. Emery placed the pin on the lapel of his father. Dr. A. D. Robertson presented Dr. Emery with an oil painting which had been painted by his daughter.

LORAIN

Speaker at the Jan. 10 meeting was Dr. Edmund E. Beard, Western Reserve University School of Medicine, who spoke on "Endocrinology in Present-Day Practice." Dr. Valloyd Adair delivered a memorial address for the late Dr. S. V. Burley.

Woman's Auxiliary . . .

By MRS. S. L. MELTZER, Chairman, Publicity Committee
2442 DORMAN DRIVE, PORTSMOUTH

Auxiliary members, please note: The 1950 Annual Meeting of the Woman's Auxiliary to the Ohio State Medical Association will be held concurrently with the Annual Meeting of the Medical Association—in Cleveland on May 16, 17, 18. The Cleveland Hotel will be Auxiliary headquarters. The full official program will appear in the forthcoming issue of *The Ohio Medical Auxiliary News.*

ALLEN

The January meeting of the Auxiliary to the Lima and Allen County Academy of Medicine was held at the home of Mrs. R. L. Tecklenberg, president. Members made 40 pairs of washable slippers to be given to St. Rita's and Memorial Hospitals. Mrs. H. A. Lotzoff gave a review of the article "Fear" from *Hygeia* magazine. Mrs. Charles H. Leech, Mrs. F. M. Flickinger and Mrs. V. H. Hay of the Program Committee acted as hostesses and served a lunch to the 28 members present.

ARE YOU AND MEMBERS OF YOUR FAMILY REGISTERED TO VOTE?

ASHTABULA

Miss Amy Parker, director of guidance and child accounting in the Ashtabula city schools, was guest speaker at the dinner meeting which members of the Ashtabula County Auxiliary held January 10 at the Hotel Ashtabula.

Mrs. Donald Forward was named chairman for the style show and tea which the group is arranging for the public in March. Mrs. E. N. Wright will serve as co-chairman. The January dinner meeting was arranged by Mrs. A. M. Mills, chairman; Mrs. Byron Johnson, Mrs. S. A. Burroughs, and Mrs. H. A. Tagett.

AUGLAIZE

The newly organized auxiliary to the Auglaize County Medical Society held its second meeting on January 19. Mrs. George Cooperrider, state president-elect, was present. There was election of the president-elect; committee chairmen were appointed; the constitution was set up; and dues of five dollars a year were agreed upon. A delegate and alternate to the state convention were chosen.

BUTLER

Ollie James, chief editorial writer of the *Cincinnati Enquirer* and author of the humorous column "The Innocent Bystander," injected a brand of wit and humor into the dinner meeting on January 18 of the Woman's Auxiliary to the Butler County Medical Society, that made the gathering a "howling" success. The husbands of the auxiliary members were guests at the meeting. Mr. James' description of his confinement in the hospital provided a particular touch of hilarity.

Mrs. Fred Brosius was in charge of the program and Mrs. W. H. Roehll was in charge of dinner arrangements. Mrs. W. H. Henry, president of the Auxiliary, greeted the guests;



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Dr. L. H. Skimming, newly elected president of Butler County Medical Society, spoke briefly. Dr. David Heusinkveld, Cincinnati, First District Councilor, was a special guest. Assisting Mrs. Roehll were Mrs. John Carter, Mrs. Charles Buchert, Mrs. L. H. Skimming, Mrs. John Bauer, and Mrs. E. McCall Morris.

FAIRFIELD

The Fairfield Auxiliary met on January 8 at the Nurses House of the Lancaster Fairfield County Hospital. Mrs. F. W. James presided over the business meeting. The project chairman, Mrs. W. D. Nusbaum, discussed matters relating to the various projects. Mrs. C. P. Smith and Mrs. W. D. Monger were named delegate and alternate respectively to the state convention.

Following the meeting, the group toured the hospital. Mr. E. J. Milarm, hospital administrator, addressed the women and told about the new wing which is to be added. Tea was served later, guests at which included two instructors in the School of Nursing and the assistant to the administrator.

FRANKLIN

The Auxiliary to the Columbus Academy of Medicine held its January meeting at the home of Mrs. Phillip T. Knies. Prior to the general meeting, Mrs. Oscar W. Jepsen, president, presided over an Executive Board meeting. Guest speaker for the afternoon was Mr. G. Walter Burwell who spoke on "The Flower of the Future." Chairman of the tea was Mrs. Richard Zollinger, with Mrs. Frank Donley and Mrs. E. R. Schumacher as co-chairmen. They were assisted by Mrs. Joseph Forrester and Mrs. Ralph Samson.

GREENE

Dr. Robert E. Boswell of Dayton was the guest speaker at the Christmas dinner party of the Greene County Auxiliary which was held at Trebein Manor. Husbands of the members were guests. Dr. and Mrs. Boswell visited in Europe last summer and the former spoke of his impressions of the countries in which they travelled.

Dr. and Mrs. H. C. Messenger also gave highlights of their trip to Europe, from which they returned recently. Both spoke of the medical aspects which interested them in England and Italy.

The dinner meeting was opened with a short talk by the Auxiliary's president, Mrs. H. C. Schick. There were covers for forty members and guests.

GUERNSEY

Members of the Guernsey County Auxiliary met on January 5 for a luncheon and business session at the home of Mrs. William Mahaffey. Two new members were introduced: Mrs. J. E.

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Patton and Mrs. Kenneth Frakes. Mrs. F. Gordon Lawyer, president, presided at the business meeting. The group which, as a Christmas project, provided a variety of useful gifts for the women residents at the County Home, voted a donation to the local tuberculosis association. The members spent the remainder of the afternoon counting and tabulating sales tax stamps which will be redeemed to finance other philanthropic projects.

Mrs. Stanley Cash, health education instructor in the Cambridge public schools, gave a very informative talk at the February meeting of the Auxiliary which was held at the Coffee Shop. Mrs. Lawyer, Auxiliary president, presided at the business meeting following the luncheon. Members voted to assist financially with the school's visual aid program.

JEFFERSON

A benefit card party was sponsored by the Jefferson County Auxiliary at the Nurses' Home of the Ohio Valley Hospital. More than 70 people enjoyed the games, and the refreshments which were served. Mrs. John Smarrella was chairman of the committee in charge of arrangements. Assisting her were Mrs. V. B. DiLoreto, Mrs. D. A. Macedonia, Mrs. John Bevan and Mrs. John Gallagher.

The Auxiliary held its January meeting at the home of its president, Mrs. Walter Cunningham. After discussing plans for future activites, the business session was followed by a social hour.

KNOX

Mrs. W. W. Brownfield spoke to the Knox County Auxiliary on January 24 at the home of Mrs. C. E. Cassaday. Mrs. Brownfield chose for her subject "Archeology of Palestine," illustrating her talk with maps, charts and pictures.

The business meeting was in charge of the president, Mrs. John Baube. Mrs. Julius Shamansky asked members to recruit donors for the Red Cross bloodmobile which was scheduled to appear on February 3. Lighted tapers and a centerpiece of red tulips were used on the refreshment table over which Mrs. Shamansky presided. Mrs. I. S. Workman and Mrs. O. W. Rapp were assistant hostesses.

LAWRENCE

The newly organized Lawrence County Auxiliary is extending an invitation to all doctors' wives in the Ninth District to attend the district medical meeting with their husbands that is to be held in Ironton on April 19. These new Auxiliary members are making elaborate plans to entertain visiting doctors' wives from the other counties in the district.

LICKING

The Woman's Auxiliary to the Licking County Medical Society met for its January dinner meet-

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ing at Wagner House, with 26 members present. Mrs. J. Y. Salzman, president, presided and introduced two new members: Mrs. Gerald Erhard and Mrs. Jay Wells.

Mrs. Paul Grove announced that work will start soon on nurse recruitment, one of the main projects of the Auxiliary. It is planned to pick a girl from the county and city high schools, worthy of the scholarship the Auxiliary gives outright. Appointments of two members to the budget committee were made. Delegates to the state convention in May are Mrs. Salzman and Mrs. Roland Jones, president-elect. Mrs. Carl Petersilge gave a resumé of the work being done by the American Medical Association in its fight against socialized medicine, and what the Auxiliaries can do to help.

LOGAN

The Auxiliary to the Logan County Medical Society held its December meeting at the home of Mrs. O. C. Amstutz, for a Christmas dinner party with the husbands of members as guests. Music and canasta were enjoyed during the evening.

On January 24, Mrs. R. A. Firmin was hostess to the group when it met at her home. Mrs. F. Blair Webster, president, presided and introduced Mrs. M. L. Pratt, secretary of the local Red Cross chapter. Mrs. Pratt spoke briefly of the blood bank and its importance to the community, and asked the Auxiliary to secure a new donor for each member on the visits of the blood bank. The members agreed to cooperate and have this as a project for the year. A social hour followed the business session.

LUCAS

The Lucas County Auxiliary held a luncheon meeting on January 17 at the Woman's Club, with Sergeant E. H. Davey of the State Highway Patrol as guest speaker. His subject was "The History, Organization and Purpose of the Ohio State Patrol." He also presented the newest ideas in traffic strategy.

A site has been purchased for the new Academy building in Toledo and the Auxiliary has been honored by being asked to have two members on the planning committee and two on the fund-raising committee.

About 40 women are attending the Art Appreciation courses sponsored by the Auxiliary and held each Friday at the Art Museum. Fifty women attended the study group session on "Live Issues of Today" held under the leadership of Mrs. Nelson Morris.

MERCER

The Mercer County Auxiliary held its regular monthly meeting on January 17 at the home of

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GYNECOLOGY—Intensive Course, Two Weeks, starting March 20, April 17. Vaginal Approach to Pelvic Surgery, One Week, starting April 3.

OBSTETRICS—Intensive Course, Two Weeks, starting April 3, June 5.

PEDIATRICS—Intensive Course, Two Weeks, starting April 3. Personal Course in Cerebral Palsy, Two Weeks, starting July 31. Personal Course in Diagnosis & Treatment of Congenital Malformations of the Heart, Two Weeks, starting June 5.

MEDICINE—Intensive General Course, Two Weeks, starting April 24. Electrocardiography & Heart Disease, Two Weeks, starting July 17. Hematology, One Week, starting May 8. Gastro-Enterology, Two Weeks, starting May 15. Liver & Biliary Diseases, One Week, starting June 5. Gastroscopy, Two Weeks starting May 15, June 12.

DERMATOLOGY—Formal Course, Two Weeks, starting May 8. Informal Clinical Course every two weeks.

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Mrs. Charles P. Adkins, with Mrs. M. G. Harnick assisting. Luncheon was served, following which the meeting was called to order by Mrs. W. C. McNeil, president. A vote of thanks was given Mrs. McNeil and Mrs. McIlroy for the very successful dinner dance held in December for the doctors of the Mercer County Medical Society.

Mrs. R. Schmidt reported that toys, brought by the members at a previous meeting, had been given to the American Legion and placed in Christmas baskets for needy families. Several ways were suggested for making money. Socialized medicine was also discussed and it was impressed upon each member the duty she has in helping to prevent Government control of medicine.

MIAMI

Nineteen wives of Miami County physicians met on January 31 at the Troy Country Club to organize a Woman's Auxiliary to the Miami County Medical Society. Officers were elected and include: Mrs. George Woodhouse, president; Mrs. William T. Wilkins, Jr., president-elect; Mrs. Kenneth F. Lowry, vice-president; Mrs. E. G. Puterbaugh, secretary; Mrs. William W. Weis, treasurer.

Present to assist in the organization were Mrs. George Cooperrider, state president-elect and Mrs. E. P. Greenawalt, second district director. Luncheon was served preliminary to the business meeting when the two state officials outlined projects for future activities.

IF YOU'RE NOT REGISTERED TO VOTE, VISIT YOUR ELECTION BOARD

MORROW

The regular monthly luncheon meeting of the Auxiliary to the Morrow County Medical Society was held on February 6. The business session was presided over by Mrs. Frank Sweeney, president. One of the chief projects of the group at the present time is the making of money to benefit the proposed County Hospital. President-elect of the Morrow Auxiliary is Mrs. Lowell Murphy.

OTTAWA

The Auxiliary to the Ottawa County Medical Society voted at the meeting on January 19 to provide a Valentine treat of cake and ice cream for the men and women at the Ottawa County Home. The meeting was held in the home of Mrs. A. D. Miessner. Mrs. G. R. Ley was appointed Auxiliary representative to the monthly meetings of the county cancer control unit. Plans for a February rummage sale were discussed.

RICHLAND

The Richland County Auxiliary held its January meeting at the Women's Club, with Mrs. C. E. Hunter and Mrs. W. H. Buker serving as hostesses. Forty members were present for

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the luncheon which was served on tables centered with pink begonias. Mrs. F. J. Heringhaus presided at the business session, following which a motion picture film on cancer, "Choose to Live," was shown.

Luncheon was served on February 6 at the Women's Club to 45 members of the Auxiliary. Valentine appointments and lighted tapers decorated the tables. Hostesses were Mrs. Joseph Bein and Mrs. Joseph Edelstein. Mrs. Heringhaus presided at the business meeting at which each member voted her cooperation with the well baby clinic's expanding program.

Mrs. Erling Smedal introduced three new members: Mrs. Paul Lee, Mrs. Frank Neff, and Mrs. Bruce Sutton. Following the business session, bridge was played.

SCIOTO

The doctors of Scioto County were the guests of honor on February 9 at a banquet given by the Auxiliary to the Hempstead Academy of Medicine in the Rafter Room of the Four Keys Restaurant. Dinner covers were laid for 70 and following the fete, Alfred Schaefer showed colored motion pictures of his extensive tour of South America. Cupids, red and white flowers and candles decorated the tables, and each doctor was presented with a valentine—each such valentine being delivered in person at the tables by specially designated "letter carriers."

The committee in charge of arrangements included: Mrs. W. A. Ray, president; Mrs. H. M. Keil, Mrs. C. L. Ferguson, Mrs. Milton Levine, Mrs. J. W. Hutchens, Mrs. C. W. Wendelken and Mrs. J. W. Daehler.

TRUMBULL

A joint dinner meeting was held on January 18 by the Trumbull County Medical Society and its Auxiliary. Guest speaker was Dr. Schneider, of the Babies' and Children's Hospital in Cleveland. The Auxiliary held its own business meeting later in the evening, continuing a discussion of plans for the Gardenia Ball. It was reported that six chairs had been purchased to be presented to the Old Folks Home of Trumbull County.

TUSCARAWAS

Mrs. Harold Wherley reviewed the history of the Auxiliary to the Tuscarawas Medical Society when its members met on January 12 at the home of Mrs. Ruel Foster. It was announced that 23 patients attended the orthopedic clinic at the hospital the previous week. Auxiliary members assist at this clinic. The organization also placed gift subscriptions of *Hygeia* in schools and youth centers, and sent a Christmas basket to the tuberculosis sanatorium. The group plans to assist in the heart fund campaign. Three new members of the Auxiliary are: Mrs. Raymond Crawley, Mrs. R. E. Wolf, and Mrs. E. L. Miller.

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October 4, 1949—Maximilian M. Kafka, Middletown, Univ. of Maryland.

December 13, 1949—Carter M. Ballinger, Parma Heights, State Univ. of Iowa; George W. Ballou, Cincinnati, Univ. of Louisville; Beatrice Bamberger, Columbus, Univ. of Maryland; Andrew M. Brenner, Hillsboro, Indiana Univ.; Lovelace B. Capehart, Jr., Dayton, Columbia Univ.; James L. Chesnut, III, Columbus, Univ. of Pittsburgh; John B. Chewning, Cincinnati, Univ. of Penna.; Wm. A. Collins, Jr., Columbus, Univ. of Tenn.; Robert L. Copeland, Cleveland, Wayne Univ.

Nathaniel J. Fine, Canton, Laval Univ.; Sidney C. Foster, Columbus, Syracuse Univ.; S. John Fung, Columbus, Univ. of Michigan; Robert A. Furman, Cleveland, Columbia Univ.; Abraham J. Gabriele, Dayton, Univ. of Vermont; Charles H. Gallup, Cleveland, Univ. of Rochester; James Hare, Parma Heights, Hahnemann Med. College; John R. Huey, Columbus, State Univ. of Iowa; Roy T. Johnson, Cincinnati, Univ. of Tenn.; Jack M. Kenyon, Toledo, Univ. of Toronto; John A. Kirchner, Cincinnati, Univ. of Virginia.

Clinton F. Lavender, Cleveland, Western Reserve Univ.; Louis A. Lorina, Youngstown, Medical College of Virginia; John E. Lynch, Cincinnati, Indiana Univ.; Benjamin Moorstein, Akron, Univ. of Michigan; James W. Papez, Columbus, Univ. of Minnesota; Joseph R. Paradise, Cleveland, St. Louis Univ.; Norman V. Petersen, Cleveland, Univ. of Pittsburgh; Fred F. Somma, Akron, Univ. of Cincinnati; Henry M. Tardif, Springfield, Univ. of Buffalo; Maurice Tatelman, Springfield, Univ. of Nebraska; Alfred A. Thurlow, Jr., Springfield, Washington Univ.; Gerard F. Wolf, Sidney, New York Univ.

Staff Appointees

Several recent appointments on the Staff of the Cleveland Clinic Foundation have been announced. Dr. Stanley O. Hoerr, formerly associate professor of surgery at the Ohio State University College of Medicine, joined the staff of the Department of Surgery. Dr. Donald B. Effler is on the staff in the Department of Thoracic Surgery. Until 1948, he was adjunct clinical professor of surgery at George Washington University. Dr. Robert A. Hays has been appointed a member of the staff in the Department of Therapeutic Radiology. He was appointed to the assistant staff in 1949. Dr. Robert E. Wise has been appointed a member of the staff in the Department of Roentgenology. He too was made a staff assistant in 1949.

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Meiling To Direct Paring of Military Hospitals

Secretary of Defense Louis Johnson on February 1 directed the inactivation, or change of status, of 18 military hospitals in continental United States.

The action marks only the first phase of a study of the total medical services problem within the Department of Defense, which is being made under direction of Dr. Richard L. Meiling, of Columbus, now director of Medical Services for the Department.

The program is estimated to effect a reduction of about 8,000 staffed hospital beds and to alleviate the acute shortage of physicians by assigning about 400 physicians to other locations in the military medical service. It is to be accomplished over a period of five months so as not to interfere with medical care of any patients. The action is expected to effect a recurring annual savings of approximately $25,000,000.

The Secretary of Defense also anticipated that substantial additional savings can be made after officials analyze smaller medical installations.

Certain of the facilities to be closed are adaptable for the needs of Veterans Administration patients. Dr. Meiling has been authorized to discuss the problem of hospitalization of V. A. patients in military hospitals with the Veterans Administration and the Bureau of the Budget, and to make arrangements for the care of V. A. patients in accordance with provisions made in the 1951 fiscal year budget for hospitalization of V. A. patients in military hospitals.

Endocrinology

A postgraduate assembly in "Endocrinology Including Diabetes" will be sponsored by the Association for the Study of Internal Secretions and the American Diabetes Association at the Roney Plaza Hotel, Miami Beach, Fla., April 3-8. Additional information may be obtained from, or application made to Dr. Henry H. Turner, secretary-treasurer, 1200 N. Walker St., Oklahoma City 3, Okla.

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Ophthalmology

Candidates for the certificate of the American Board of Ophthalmology are accepted for examination on a written qualifying test. These tests are held annually in various parts of the United States. Applications are being accepted for the 1951 written test. They will be considered in order of receipt until the quota is filled. Practical Examinations for acceptable candidates in 1950 will be held in Boston, May 22-26; Chicago, October 2-6.

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Ohio Society for Crippled Children To Sponsor Easter Seal Drive

In 1949 the Ohio Society for Crippled Children grossed $375,833 from Easter Seals. More than 90 per cent of this amount was retained in Ohio while 08.3 per cent was sent to the National Society. Seventy-six per cent of that retained in the state was expended in local communities while 15.7 per cent was used by the State Society.

Society officials revealed that actually more than $392,000 had been expended in Ohio during the last fiscal year for crippled children's work. The additional amount above the Easter Seal receipts was made possible by special donations. Because of the increased needs and mounting costs of services, Society officials hope to increase their budget for the coming year. The Ohio Society for Crippled Children, with headquarters at 5 W. Broad St., Columbus 15, acts as an administrative, coordinating and supervisory organization to more than 60 local county societies for crippled children throughout the state. County organizations are administered largely by volunteer workers.



OHIO BOY FEATURED

Six-year old Russell Miller of Columbus has been singled out as the national Easter Seal Boy in the annual campaign for crippled children, March 9 to April 9.

The child is a cerebral palsy victim who has been receiving treatment since he was three years old at the Cerebral Palsy Treatment Center, 620 E. Town St., Columbus, sponsored by the Franklin County Society for Crippled Children.

Russell's real chance for rehabilitation came in 1946 when the center, one of the first in the country, was opened. He has progressed to the point where he was admitted on February 1 of this year to Open Air Elementary School, a Columbus public school for crippled children.

The National Society was founded by Edgar F. "Daddy" Allen in Elyria, 29 years ago. Officers point out that it is guided by a three-point program for the nation's handicapped—education, research and direct services, financed by Easter Seal campaign. Cerebral palsy claims nearly 200,000 victims in the United States. It is estimated that there are 8,000 cerebral palsied children in Ohio.

Since opening of the Columbus center, similar centers for pre-school children have been established in Cleveland, Dayton and Bowling Green. Several other communities offer at least one of the therapies required for restoration of cerebral palsied children.

IF YOU'RE NOT REGISTERED TO VOTE, VISIT YOUR ELECTION BOARD

Eye, Ear, Nose and Throat

A Seminar in Otolaryngology-Ophthalmology will be held April 17-21 at the New York Polyclinic Medical School and Hospital, 345 W. 50th St., New York City 19. Additional information may be had by writing the Medical Executive Officer.

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Dr. Curtis Twice Honored For the Year

Dr. George M. Curtis, chairman of the Department of Research Surgery at the Ohio State University College of Medicine, has been twice honored for outstanding work in his field.

He has been selected as one of two persons to receive the 1950 recognition award presented by the Professional Inter-Fraternity Council at Ohio State University. The Council, whose membership is made up of 12 professional groups on the campus, yearly singles out two persons "who have made marked contributions to their fields and have brought honor to their fraternities." The award was made at the annual recognition banquet on February 15. Dr. Curtis was awarded the recognition certificate by Alpha Kappa Kappa, medical professional fraternity. He has been associated with the University faculty for 18 years. Other recipient of the award is Bernard V. Christensen, Ph. D., dean of the College of Pharmacy, O. S. U.



G. M. CURTIS, M. D.

Dr. Curtis also was chosen for the 1950 honor award of the Mississippi Valley Medical Society. This award is given from time to time "to those who have made distinguished contributions to clinical medicine." The award will be presented at the banquet of the Society in Springfield, Ill., on September 28. He was recently awarded a $3,000 research grant by the Ciba Pharmaceutical Co. to support research studies on hyperthyroidism.

COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Cleveland, May 16-18.

American Medical Association, Annual Session, San Francisco, June 26-30.

American Association of Industrial Physicians and Surgeons, 35th Annual Meeting, Sherman Hotel, Chicago, April 22-29.

American Association for Thoracic Surgery, Denver, Colo., April 15-19.

American College of Physicians, Boston, April 17-21.

American College of Radiology, San Francisco, Calif., June 25.

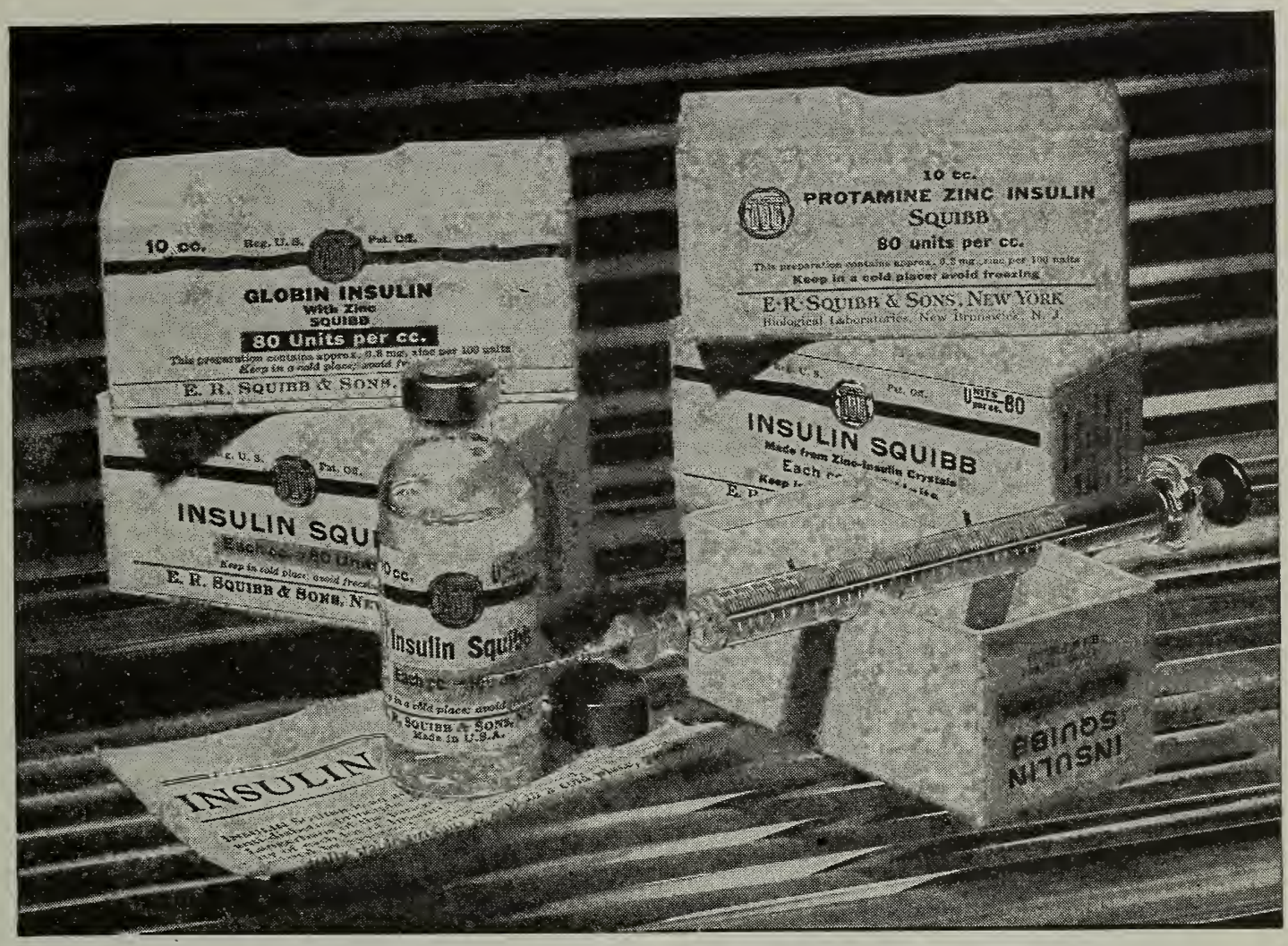
American Goiter Association, Shamrock Hotel, Houston, Texas, March 9-11.

American Pediatric Society, French Lick, Ind., May 8-10.

National Tuberculosis Association, Washington, D. C., April 25-28.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Life Among the Doctors, by Paul de Kruif ($4.75. *Harcourt, Brace & Co., New York City).* From their beginning we have followed the writings of Paul de Kruif, sometimes with pleasure, sometimes with irritation, and always with interest. Bacteriologist made angry, turned pamphleteer, historian, and finally crusader, de Kruif has made a greater contribution to the ultimate health of the nation than most physicians. He has done this mostly by shortening the interval between discovery and practical, everyday application of advances in medicine. Sometimes he has been altogether too premature. Carried away with his enthusiasm he has, at times, made mistakes, but in general his writings have been helpful.

In this volume, it becomes quite clear that he has always wished to be a physician and that now as he looks back in these pages, he takes his satisfaction in the wholesale manner in which he has been allowed to serve Medicine although he has been unable to serve the individual sick.

De Kruif never overestimates the amount of information that his readers possess and he never underestimates their intelligence. He marshals the facts that his readers lack the ability to appeal to their emotions as to their minds. He writes most effective melodrama. Virtue after travail and suffering overcomes all obstacles and triumphs over wickedness, ignorance, and apathy.

In his enthusiasm, de Kruif permits his readers to draw mistaken conclusions. He is a hero worshiper with strong loyalties and a deep hatred for what he deems to be ignorance, prejudice and injustice blocking the path of his heroes. Sometimes he is also mistaken in these. For instance, he allows his concept of the stubborness of Morris Fishbein to overlook the great responsibility to established truth to the sick that the former Editor of the *Journal of the American Medical Association* has. He dramatizes this responsibility into what he considers the backwardness and reactionary attitude of all the physicians who belong to the American Medical Association.

At his best, de Kruif has just the right degrees of suspense and timing to pull our heart strings as he describes the fifty-odd living researchers in public health and clinical medicine as his life among the doctors.

As de Kruif matures, however, we find him looking up from the struggles of his heroes to the problems of medical care with a sympathetic eye for our profession. He knows as well as we do that the nationalization of Medicine will only set back its work. Like most laymen and those physicians who have never practiced their art, he is oversold on the advantages and the merits of group practice. This view he defends with a fierceness born of his loyalty to Dr. Sidney Garfield. As he studies the current controversy of socialism by which we shall share our poverty and our increasingly inadequate medical facilities, we can rest assured that de Kruif will be in there fighting for personalized ministration by personal physicians.

There is not a dull moment in this whole book and those of us who are interested in the use of words as a means of communicating the meaning of science to laymen, can learn much from a study of this book.

Fundamentals of Otolaryngology, by Lawrence R. Boies, M. D., ($6.50. *W. B. Saunders, Philadelphia, Pennsylvania),* is a new text by the author and other members of the Staff at the University of Minnesota. It has presented the essentials in a clear and understandable way. If you have not refreshed yourself about the progress in this field, it would be wise to avail yourself of the chance to read this text.

Oral Bacterial Infection: Diagnosis and Treatment, by Lyon P. Strean *(Dental Items of Interest Publishing Co., Inc., Brooklyn, New York),* is a well written text for medical and dental students and for all who want up-to-date information quickly. For this reason, the author has paid an unusual amount of attention to his index and the result is a thoroughly workable manual. The author is a well known worker in this field.

Hemorrhagic Disorders: A Guide to Diagnosis and Treatment, by Paul M. Aggeler, M. D., and S. P. Lucia, M. D., ($10.00. *University of Chicago Press, Chicago, Illinois)* is a unique book attempting to present in elaborate charts the subject of abnormal bleeding in a way that we can all understand. The pages of the text were reproduced from an exhibit designed for use in teaching at the University of California Medical School. Consequently, the book is streamlined. In our opinion, we need more texts like this.

The Psychoanalytic Study of the Child, Volumes III and IV ($10.00. *International Universities Press, Inc., New York City),* contains nine papers dealing with the problems of psychoanalytic theory and of child development; eleven on clinical problems; two on guidance work; two

on the problems of group psychology. These are followed by a survey of the literature on feeding problems of psychogenic origin and an essay on a historical topic, i. e., Child Psychiatry in 1830. In all, a worth-while book on the status quo.

Marriages Are Not Made in Heaven, by Janet Fowler Nelson *(Woman's Press, 600 Lexington Avenue, New York City)*, is a manual on family relations presented to the public after a thorough trial by the committee of the Y. W. C. A. It is intended to meet the need of the working girl.

Siam Doctor, by Jacques M. May ($2.75. *Doubleday & Company, New York City)*, is the story of this man from October, 1932, to June, 1940, and his experiences in Siam.

Physiology of Thought, by Harold Bailey, M. D., ($3.75. *William-Frederick Press, New York City)*, is designed to be a functional study of the human mind in action. It presents pretty largely the concepts of the author as they have been built up without reference to others and, therefore, tends to be dogmatic; however, the approach is right. The book, therefore, deserves critical reading.

Handbook of Medical Management, by Milton Chatton, M. D., Sheldon Margen, M. D., and H. D. Brainerd, M. D., of the staff of the Medical School of the University of California ($3.00. *University Medical Publishers, P. O. Box 761, Palo Alto, California)*, is a 475-page manual of the size to fit in the pocket of the House Officer—a real pocketful of information arranged in the most usable way.

Granulomatous Inflammation, by Wiley D. Forbus, M. D., ($2.00. *C. C. Thomas, Springfield, Illinois)*, is publication number one in a series of American Lectures. These beautiful little books just by their format bring joy to your reviewer's heart. It is hoped that lectures by equally as authoritative persons may come to us instead of stuffy, overpadded books which are that way because we have not found any way to distribute these smaller and more efficient books.

The Arthropathies, by Alfred A. deLorimier, M. D., ($7.00. Second Edition. *The Year Book Publishers, Chicago, Illinois)*, comes six years after the first edition. There are many new photographs to make this handbook of Roentgen Diagnosis worth while to all who see X-ray pictures of sick joints.

Essentials of Obstetrical and Gynecological Pathology, by Robert Faulkner, M. D., and Marion Douglass, M. D., ($8.75. Second Edition. *C. V. Mosby Company, St. Louis)*, is welcome. Two of our members of the Staff of the Western Reserve University Faculty have assembled the scattered information on pathology to be found in the clinical literature of this field. There are many improvements in this edition. A good book of reference for the house staff and for those who are especially interested in the subject.

Birthday Book for the Fiftieth Birthday of Professor Aarno Turunen, being Supplement Three to Volume 38 of Annales Chirurgiae et Gynaecologiae Fenniae. Six hundred pages of gynecology as practiced in Finland. All done in honor of a great physician and a great citizen.

Mobilization of the Human Body, by Harvey E. Billig, Jr., M. D., and Evelyn Loewendahl, M. A., ($2.00. *Stanford University Press, Stanford, California)*, presents newer concepts on body mechanics. The work is timely as we physicians are called upon more and more to help adapt the human body to meet the demands of the mechanization of even the simpler tasks.

Progress in Neurology and Psychiatry—An Annual Review edited by E. A. Spiegel, M. D., ($10.00. Volume IV. *Grune & Stratton, New York City)*, is composed of nearly 600 pages of contributions by a large number of distinguished workers in the field. This gives a comprehensive coverage of the year's progress.

The Origin of Medical Terms, by Henry Alan Skinner ($7.00. *Williams & Wilkins, Baltimore, Maryland)* is an attempt by the professor of anatomy at Western Reserve University to place in our hands a general reference book of standard medical terms, particularly those likely to be encountered as one enters the study of medicine. In our mixed language, there is room for a book as well done as this one.

Chemotherapy of Leukemia and Leukosarcoma, by William Dameshek and his associates at The New England Medical Center ($4.75. *Grune & Stratton, New York City)*, is a beautiful reproduction of an exhibit at the American Medical Association Convention in June, 1949. This new method of presenting teaching material is worthy of much recommendation, especially in these days of LOOK and LIFE level of literacy.

Atlas of Drawing for Chordate Anatomy, by Samuel Eddy, Professor of Zoology, University of Minnesota ($3.50. *John Wiley & Sons, Inc., New York City)*, is a book of unlabeled drawings of the structures of animals commonly studied in comparative anatomy. In 1915, your reviewer introduced the idea of an illustrated notebook in pathology based upon the same principle that has governed the production of this book, i. e., the average student will spend more time making mediocre drawings than the results will justify.

Dental Roentgenology, by LeRoy M. Ennis, D. D. S. ($10.00. *Lea & Febiger, Philadelphia)*, makes every effort to correlate the radiograph with the pathology by giving an explanation of each.

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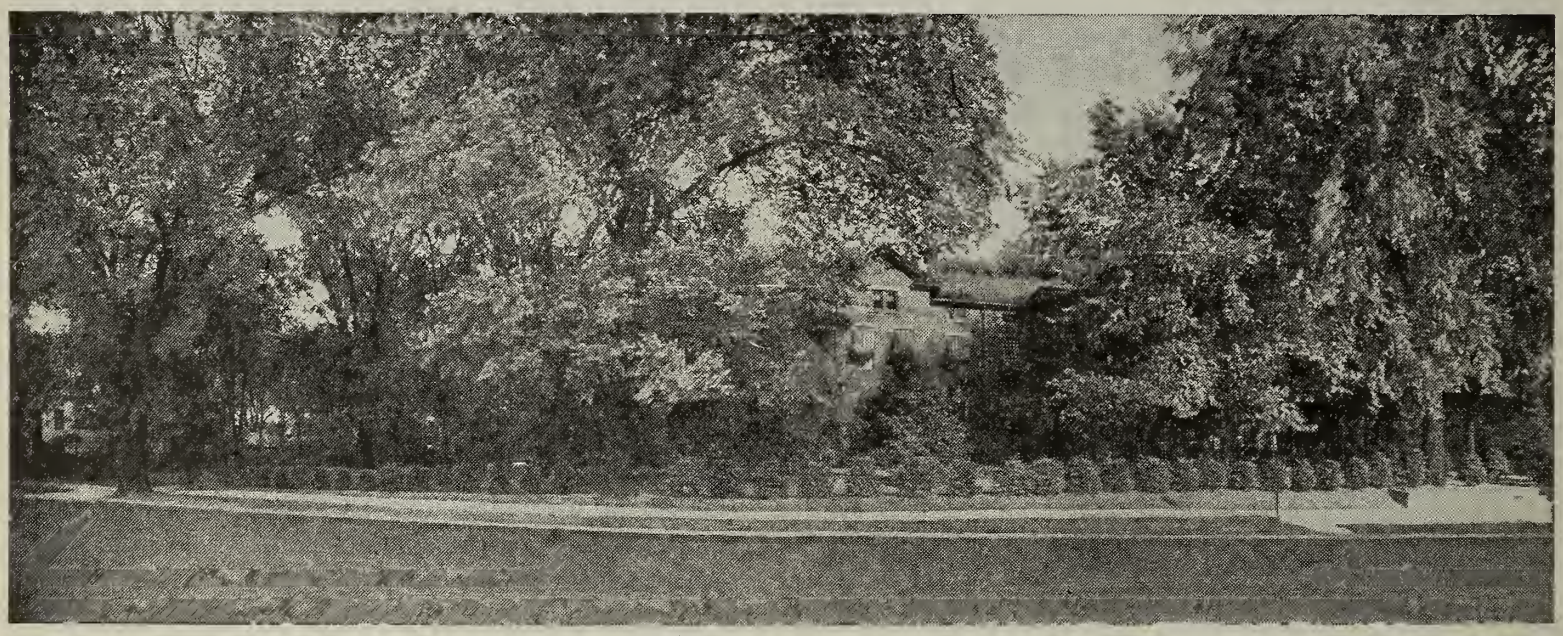
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Arterial Infusion*

DONALD E. HALE, M. D.

ARTERIAL infusion is the injection of blood or other fluid under controlled pressure into an artery. The needle, or cannula, is directed toward the heart so that the fluid passes up the artery to the aorta instead of in the ordinary peripheral direction. The fluid injected should be blood, but in a grave emergency saline or glucose solutions may be used and are quite effective for short periods of time. The procedure is most clearly indicated in severe cardiovascular collapse as the result of hemorrhage.

Arterial infusion performs two vital functions. The first is that of supplying blood or other fluid to the patient's cardiovascular system. This can also be accomplished by the intravenous administration of fluids. The second, and more important, is the building up immediately of sufficient pressure in the aorta so that blood flow to the coronary and cerebral arteries is reestablished. The intravenous route is satisfactory in patients who have a systolic blood pressure as low as 50 mm. of mercury inasmuch as fluid infused into the vein is in the arterial circulation a few seconds later. But in individuals in whom there is cardiac arrest or greatly diminished cardiac output, with indiscernible pulse and absence of blood pressure, arterial infusion affords a means of taking over temporarily the function of the heart by supplying blood to the aorta and thence immediately to the myocardium and the brain.

APPARATUS

The apparatus consists essentially of a Kelly flask containing the fluid to be administered, the means of applying a measured pressure to the air over the fluid and a tube which delivers the fluid from the flask to the artery. The mouth of the Kelly flask is fitted with a rubber stopper through which a short glass tube connects by means of a rubber tube to a hand pressure bulb and aneroid manometer. The commercial blood flasks which are now generally available can be adapted to this use by simple modifications. The small-mouthed commercial flask is modified by removing the ball valve and replacing it with a glass tube which reaches from the neck of the flask to within 1 cm. of the bottom. The wide-mouthed flask is already equipped with such a glass tube. In either case, the pressure is applied through this glass tube to the volume of air over the solution. The commercially available disposable plastic tubing may leak if pressures of 200 to 300 mm. of mercury are applied and should, therefore, either be ligated in place or should be replaced with a rubber tube. The rubber tube, when used, should have a fairly thick wall with a small lumen and should terminate in an adaptor which will fit a 15 gauge needle or cannula.

An ordinary Murphy drip may be interposed in this tube although it should be pointed out

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* Part VI of a Symposium on "Acute Cardiorespiratory Failure: Requirements for Successful Resuscitation," presented at the Annual Meeting of the Ohio State Medical Association, Columbus, April 19-22, 1949.

that a danger of this arrangement is the possibility of forcing small bubbles of air down through the delivery tube and so into the patient's artery. Small quantities of air are ordinarily well borne by the patient when given intravascularly but in a patient with absent blood pressure to whom blood is administered rapidly, small air emboli may be carried up into the aorta and thence into a coronary or carotid artery with, perhaps, serious consequences. A Murphy drip with a bent tip which delivers its stream toward the side of this apparatus may help to prevent this occurrence. An even better device is a modification of the Murphy drip which is manufactured in England.* This contains a glass float, the tip of which is ground to fit the bottom of the Murphy drip so that with the last of the fluid the Murphy drip is sealed and no air can enter the artery. It should be clearly pointed out that the danger of massive air embolism with the apparatus described is a real possibility and every precaution should be taken to prevent this occurrence.

Another modification of the equipment consists of a 10 or 20 cc. syringe fitted either with a double valve or a three-way stopcock. The blood or fluid is led to the valve or stopcock and is then conducted by another tube to the artery. If the syringe becomes sticky and begins to bind in use it may be replaced by a clean one, or the plunger of the syringe may be covered by a loosely fitting Penrose drain, containing a small quantity of citrate or heparin solution. This Penrose drain is secured by a silk ligature around the syringe barrel and also around the neck of the plunger. This prevents drying and contamination of the plunger, and the solution affords adequate lubrication. Massive air embolism is much less likely with the use of this apparatus.

TECHNIQUE

Arterial infusions may be administered through any available artery. The femoral artery may be used if it has a pulse which permits accurate identification of its position. The aorta, when it is present in the operative field, whether in the chest or abdomen, may be the site of the needle puncture. The radial artery is ordinarily employed because of its ready accessibility, its fairly superficial, long, straight course in the wrist, and because it can ordinarily be sacrificed without danger at the end of the procedure. The apparatus is set up, the tubing is filled with the fluid to be used and the tubing clamped near the needle or cannula. The artery is isolated and opened by means of a small incision. The cannula is inserted and secured in place by means of a ligature. The pressure above the fluid is now adjusted so that it is between 100 and 300 mm. of mercury. The clamp is removed and the fluid allowed to flow. The blood pressure of the patient is checked frequently either by the conventional means of stethoscope and inflatable cuff or by reducing the pressure over the fluid until it just stops flowing. At this point, if the meniscus of the fluid is level with the patient's heart the reading on the manometer dial gives an accurate reading of the radial systolic pressure.

Inasmuch as the procedure attempts to replace the action of the heart temporarily it is safe to start the infusion of fluid at a pressure of 300 mm. of mercury. It may be desirable to use a smaller pressure in arteriosclerotic individuals. The pressure should be reduced as soon as a reasonable blood pressure has been established and at this point the infusion should be continued slowly at a pressure which is only 10 to 20 mm. of mercury above that of the patient. Even though fluids are being administered intravenously at the same time it is well to leave the cannula in place until the blood pressure has been reestablished and has reached equilibrium at a safe level. At the conclusion of the infusion the radial artery may be ligated and the incision closed. It is not too difficult a matter, however, to resuture the incision in the artery using 7-0 silk on an atraumatic needle. If resuture of the artery is contemplated, the longitudinal incision is the one of choice.

RESULTS

It has been demonstrated experimentally that opaque medium injected into the brachial artery of a dog will reach the coronary and carotid arteries almost immediately. In one such experiment the blood pressure was reduced to 20 mm. of mercury, whereupon 12 cc. of radio-opaque medium was injected into the brachial artery. An X-ray taken five seconds after the beginning of the injection demonstrated clearly a satisfactory filling of both coronary arteries, both carotids and vertebrals and all of the major cerebral vessels. In another experiment, cardiac activity following two minutes of complete cardiac and respiratory arrest following blood letting was reestablished by means of arterial infusion alone.

PRECAUTIONS

It is important, of course, that the blood given by this method be cross-matched with that of the patient whenever possible. Although, in an emergency, type O blood with an agglutinin titre less than 1 to 64 may be used with safety. It should be emphasized that the greatest care must be exercised in the intravascular injection of fluids under air pressure in order to avoid the danger of massive air embolism.

CONCLUSION

Arterial infusion affords a valuable emergency means of reestablishing coronary and carotid circulation in severe hemorrhagic hypotension.

* MacIntosh drip, A. Charles King Co., Ltd., London.

Sinusitis Due to Bacterial Allergy: Identified by Tissue Culture and Treated by Specific Desensitization

HERMANN BLATT, M.D., and FRANK A. NANTZ, M.D.

CHRONIC sinusitis cases which presented an obscure etiology or failed to respond to standard treatments were tested for hypersensitivity to bacteria. Approximately 78 per cent of those tested were found positive to two or three strains of bacteria and were given a course of desensitization. Nearly all of these responded well (see below).

Because the theoretical basis for testing and treating these patients for bacterial hypersensitivity had not as yet been fully established, we were frankly very skeptical at first about undertaking this program. The patients, however, having suffered so long from sinusitis, were willing to "subject themselves" to any experiment. Now, with almost two years of remarkably successful experience treating these cases in this manner, we feel we should communicate our experiences in the hope of stimulating further investigations along these lines.

DISTINCTIVE CHARACTERISTICS OF SINUSITIS DUE TO BACTERIAL HYPERSENSITIVITY

(1) Virtually all these patients said in their histories that their first attacks followed fall and winter colds, and were accompanied by a low grade temperature. These attacks had then become increasingly more frequent, until the patient suffered from almost constant attacks of sinusitis even though in the fall and winter months or on damp days their symptoms were more marked.

(2) On examination these patients taken as a whole, had thick yellowish postnasal drips, their nasal turbinates were markedly congested, not necessarily livid, and on transillumination, there was some haziness of the frontal sinuses. Nasal smears did not necessarily show marked eosinophilia, in contrast to pollen types of nasal conditions, such as allergic rhinitis.

(3) All cases were excluded to pollen sensitivity by skin tests. Many, on the other hand, showed positive reactions to skin tests for dust. Their bacterial hypersensitivity findings, however, being in all cases so marked, it was decided to desensitize to the bacteria first. In the end, in fact, after we began our tissue culture studies, none were ever desensitized to dust, because their conditions improved sufficiently on a program of densenitization to bacteria alone.

(4) All cases had previously been treated for their sinus conditions over long periods of time, but had failed to respond to the treatments given. According to their histories, they had been given such therapy as: Commercial stock respiratory vaccines, antibiotics, antihistaminics, frequent washings of the sinuses, infra red, and vitamins. It was interesting to note that in contrast to other forms of allergic nasal conditions, antihistaminics had given no relief whatsoever.

(5) All these cases at the present moment are markedly improved. Some of them have been under treatment for as long as two years. In consequence, we feel fairly confident that their improvement is reasonably stable, at least as long as the maintenance program is carried out. They all no longer get repeated attacks of colds in winter. If they do happen to get a single attack, it is much less severe and of shorter duration. Most of them no longer have any postnasal drip and in those that do, the character has changed to a thin, clear type.

DIFFICULTIES OF THIS TREATMENT

The disadvantages of this method of approach are that the course of desensitizing is long drawn out; many patients, when improved, discontinue treatments before the end of their program of desensitization. All patients, at some time in their early course of treatment, get focal flare-ups, which discourages some. Clinical signs of improvement, furthermore, are seldom seen before four months' treatment, so that it is hard to convince some patients of the efficacy of this program.

From the physician's point of view, the disadvantage lies in the fact that filtrates can contain no preservative, since even minute amounts of preservatives affect the antigens. This increases the danger of contamination and

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frequent sterility tests must be run, so as not to endanger the patient. Furthermore, a separate tuberculin syringe must be used for each patient, and after each use the syringes must be flushed in triple distilled water. The pyrogens in double distilled water seem to affect the antigens.

COMMON CHARACTERISTICS OF ALL CASES OF BACTERIAL HYPERSENSITIVITY

Despite the almost unbelievable number of different symptoms manifested by people suffering from hypersensitivity to some one or another strain, there are nonetheless certain characteristics common to all.

(1) Antihistaminic drugs have no, or a negligable ameliorating effect.

(2) When a patient is positive to one strain of bacteria, he is invariably sensitive to two or three others.

(3) The strains to which a patient is positive are frequently unrelated in a serological sense. The studies we have done thus far seem to indicate that the colony form is of more importance.

(4) At some time during the course of desensitization, most patients have some form of mild, short reaction. Usually there is only one, if the dosages given are not too large or too strong. The reaction for any given individual is always of the same type, regardless of its duration.

(5) These reactions can be induced at will by raising the strength or the amount of dosage. In fact, all the original symptoms of the disease can be reproduced at will at any time, merely by giving a sufficiently large dose of the filtrate.

(6) Many patients are never able to tolerate high dilutions such as 1:10 or full strength. These should be maintained on dilutions of 1:100 or even 1:1000.

(7) In cases of chronic sinusitis, as well as other types of bacterial hypersensitivity, we found that though we took nose and throat cultures in 80 per cent of the cases during an acute phase and before any therapy had been started, the tests were never as markedly positive with the autogenous material as with our stock filtrates. There was a correlation only in the sense that the throat cultures would frequently show organisms related to the ones to which the patient was positive. The few cases treated with autogenous filtrates did not respond as well as those treated with stock filtrates.

PROCEDURE FOR MAKING TISSUE CULTURE SURVEY

Each patient initially is tested on three different occasions to about 100 bacterial filtrates. Only those patients who come down consistently positive to the same strains on each occasion can be termed positive, because of the possibility of error in reading the slides and the possibility of false serological reactions.

For each test 9 cc blood are drawn and poured into 1 cc of 2 per cent sodium citrate solution. The white cells are separated out and a cell suspension made in Ringer's solution.

To test for hypersensitivity to a particular strain of bacteria, one drop of filtrate, one drop of the cell suspension, and one drop of full strength thrombin are put together on an ordinary glass slide and incubated for 18 hours.

At the end of this time, if the patient's leucocytes are positively hypersensitive, the cells have become necrotic, crenated and stippled. If not hypersensitive, they have remained viable. This procedure has been described in detail in the Annals of Allergy[1, 2] and other articles still in publication.

PROCEDURE FOR DESENSITIZATION PROGRAM

To desensitize a patient, we use the same filtrate to which he was positive. We prepare dilutions starting with 1:1,000,000 and increasing the concentrations to 1:100,000, 1:10,000, 1:1,000, 1:100 and sometimes 1:10 and even full strength. First we skin test the patient to 1/20 cc of the one to a million dilution. The subcutaneous inoculations are increased by 0.1 cc every three or four days, so long as there are no reactions. If a reaction occurs, the dose is repeated until it is well tolerated.

When the patient is down to 1:100 dilution, or if he gets reactions and tolerates only 1:1,000, his tissue culture is repeated for the bacteria to which he was originally hypersensitive. If the desensitization program is responsible for his improvement, his tissue culture will now be negative or only slightly necrotic.

The following five cases are typical examples of sinusitis due to bacterial allergy and their response to treatment.

TYPICAL CHRONIC SINUSITIS WITH FLARE-UPS AND SECONDARY CHEST INFECTIONS

C. K. B., male, age 32, eleven-year history of upper respiratory attacks. Each of his frequent bad colds was followed by a sinus flare-up so bad the entire face hurt. His entire chest filled up, he frequently sneezed explosively, had some discharge from his nose, but was bothered more by a thick postnasal drip. He said at first these attacks came only in winter but now came all year round. His past history was not remarkable except that in 1942 he had supposedly had an attack of bronchitis associated with pleurisy.

First seen June 5, 1948, during an attack. Temperature was 102 F. Frontal sinuses and both antra showed marked haziness to transillumination. Nasal passages were edematous and livid with a thick postnasal drip. X-ray of chest showed increased hilar markings. The white count was 12,800, polys 73 per cent, eosinophiles 2 per cent. Urine was negative. Serology negative. Nasal smear showed one eosinophile on the entire slide, many bacteria. The throat cultured showed staphylococci.

The diagnosis at the time was acute pansinusitis, with possible bronchitis. After the attack had subsided, tissue culture surveys were made on

three different successive days to approximately 100 different bacterial strains. He came down consistently positive to Strains 6011, 9882, 1039 and 1313, i.e., two strains of Group A hemolytic streptococci, one staph aureus and one staphylococcus albus strain.

He was put on a program of desensitization to these strains. When the dose was stepped up from 1:1,000,000 concentration to 1:100,000 he got a mild flare-up. He had a second flare-up when changed to 1:1,000 dilution. Eventually he was able to tolerate a dose of 1 cc. of full strength dilution.

On July 30, 1949, he was reexamined. At this time his general physical condition was improved. "He felt better, wonderful." This was the first winter in years that he had had no colds and no sinus condition. The chest findings were negative. The nose was no longer edematous or livid. The nasal smear showed no eosinophiles. He was retested for hypersensitivity but was found negative to all bacterial to which he had originally been positive. Nevertheless, as a precaution, he is being maintained on injections of full strength dilution once a week.

CASE TREATED BY VACCINES, ANTIHISTAMINICS AND BACTERIAL FILTRATES

M. C., female, age 44, reported a history of recurrent attacks of sinusitis for years, frequently associated with a temperature of 101-2° F. The attacks in the last two years had become so severe she had had to go to bed and give up working. She did not remember whether the attacks had originally started in winter but they were then all year round. When she was younger she had had frequent sore throats. In 1944 she had had pneumonia followed by pleurisy. No history of any allergies.

When seen October 1944, her nasal turbinates were very livid, and so markedly congested that she could hardly breathe through them. Her temperature was 100. She had a thick, yellow postnasal drip. The chest X-ray showed some parenchymatous infiltration and a pleuritic thickening along the right border of the cardiac shadow, apparently the result of chronic pleurisy. The rest of the parenchyma was clear. Diaphragmatic excursions on fluroscopy were not impaired. The chest was clear to auscultation and percussion. Her nose and throat cultures showed: Hemolytic streptococcus, non-hemolytic streptococcus, green streptococcus, staphylococcus albus, hemolytic staphylococcus aureus, staphylococcus citrus. The white count was 5,600 differential: Polymorphonuclear neutrophiles 58, lymphocytes 34, large mononuclears 6, eosinophiles 2.

At the time this patient first came to us we had not yet begun our tissue culture studies for bacterial hypersensitivity. In consequence, we naturally gave the patient skin tests for cereals, epidermals, molds, grass pollens, tree pollens, cottonseed, flaxseed, dust (stock and from home), kapok, orris root, pyrethum, and tobacco. With the exception of a marked positive reaction to both forms of house dust, she was negative to all. She received a desensitization program with dust and autogenous vaccine, with no results. When the antihistaminics appeared, she was given a trial therapy with benadryl and later pyribenzamine, again with no results.

By December, 1947, we were satisfied enough by our findings to survey her for bacterial hypersensitivity to all the strains we had at that time. On four successive occasions she came down consistently positive to two strains of Group A hemolytic streptococci. A program of desensitization was begun. At first she got such marked focal flare-ups after each injection that she quit coming, and had to be convinced to resume treatments.

By the fall of 1948 the patient was almost asymptomatic. On January 25, 1949, she had a slight cold and a very mild sinus attack. Since then she has been entirely free of any colds or sinus flare-ups. Her tissue culture survey, repeated March 3, 1949, was entirely negative. As of June, 1949 she still has a slight postnasal drip, but it was of a thin, clear character. Her turbinates were no longer edematous or livid. She is being maintained once a week on a full strength dilution.

SEVERAL FLARE-UPS DURING DESENSITIZATION

W. R., male, age 30, had had recurrent attacks of sinusitis for years. These originally came only in winter, but now were all year round. They were accompanied by frontal headaches, a boring sensation in the eyes, ocular vertigo and a feeling of pressure in the ears. He "wheezed" at times whenever the attack was associated with general upper respiratory infections. The rest of his medical history was not remarkable. He had no allergies.

On July 22, 1947, there was a cloudiness of the right frontal sinus on transillumination. This was later confirmed by X-ray. The nasal turbinates were congested. The pharynx was angry-red. He had a very thick yellowish postnasal drip. The ear drums showed a poor light reflex, the hearing, however, was normal. There was pressure tenderness over both foramens supraorbitalis.

The patient made roughened breath sounds. The X-ray of the chest showed some increased hilar markings. Red blood count was normal, white count (taken during an acute attack) was 13,550, polymorphonuclear seg. 70, polymorphonuclear non seg. 6, lymphs 25, eosinophiles 4, monocytes 2. The urine was negative. The corrected sedimentation rate was 10. The nasal smear showed no eosinophiles. Skin tests to pollens proved negative, but to dust slightly positive.

Tissue culture surveys were done on three different occasions. He was found positive each time to two Group A hemolytic streptococci and one mold. (Skin tests to molds had all been negative.)

He was put on a program of desensitization with these filtrates. Two hours after being given 0.4 cc of the 1:1,000,000 dilution, he had a marked focal flare-up; his nose was congested; he had a sinus headache and a slight temperature. The same dose had to be repeated five times. Each time until the last time, the reaction occurred in the same manner. When the patient received 0.4 cc of 1:100,000 dilution, the same phenomena occurred and the dose had to be repeated twice. When the patient received 0.1 cc of 1:1,000 dilution, he had a slight reaction. After that he had no more.

On February 25, 1949, his examination showed no postnasal drip. His chest was clear and the patient stated it was the first time in years that he had had no sinus flare-ups during the winter. He was at that time on 0.5 cc of 1:100 dilution.

May, 1949, the patient refused further treatment. He claimed he had been free of attacks for months and could not see the rationale of continuing treatments without any symptoms.

FIRST INJECTIONS FOLLOWED BY FLARE-UPS

B. S., female, age 22, gave a history of recurrent attacks of sinusitis since the age of 16. These were often followed by bronchitis, associated with fever and a loss of weight. No wheezing. The balance of the history was not remarkable. She had had no atopic allergies, however, the sister had hay fever and asthma and the mother had hay fever and migraine headaches.

On September 27, 1946, her left frontal sinus was cloudy. The nasal turbinates were markedly congested, not livid in color. She had a thick yellowish postnasal drip, and her pharynx was red and angry looking. Serology negative. Complete blood count normal (no eosinophiles). Urine negative. The sputum was negative for acid fast. The nasal smear showed no eosinophiles. X-ray of the chest was negative. Other physical findings were all negative. The nose culture revealed staphylococcus aureus in pure culture. The throat had streptococcus viridans and staphylococcus aureus. She was negative to all skin tests.

She was treated with autogenuous material with no results. Her sinus attacks became more frequent and during the winter of 1947 she had two fairly severe attacks of bronchitis following sinus attacks. Antihistaminics gave no relief.

In the fall of 1947 tissue culture studies were done on three successive occasions. She was positive on each occasion to one Group A hemolytic streptococcus and one staphylococcus aureus strain. No tissue culture study was made using autogenous material. It may be possible that the staphylococcus aureus strain found in her throat was the same as that found in the tissue culture studies.

A program of desensitization was begun. In the beginning she got marked flare-ups a few hours after her injection so that she had to be kept on the minimal dose of 0.1 cc of 1:1,000,000 dilution for quite a while. After several injections with this dose the flare-ups disappeared and her condition became steadily better.

January, 1949, her tissue culture survey was repeated and she was found negative to all bacteria. June, 1949, she was reexamined. She had had no attacks for months and her physical findings were entirely negative. She, however, still did not tolerate full strength filtrate (her arm gets red and sore) and so is maintained on 1:10 dilution.

PICTURE OBSCURE BECAUSE OF MECHANICAL OBSTRUCTION

G. B., male, age 41, had a history sinusitis for the past eight years. His first attacks had come in winter, but now were all year round on damp or rainy days. The attacks had become so severe that the patient was often incapacitated from work and had to go to bed. When having attacks, the coffee beans (where he worked) made them worse. Location did not seem to play a role for he had tried other climates with no result. The only factor which seemed to affect him was the weather. Food, drugs, temperature, smoke and excitement all seemed to play no role. The attacks were not associated with sneezing and relief following them was complete. He had a thick nasal discharge during attacks and severe frontal headaches, frequently nausea. He had no history of atopic allergies but had had active tuberculosis 14 years before. When 15 he had broken his nose.

November 16, 1948, his sinuses were slightly hazy to transillumination, the septum markedly deviated to the left. The nose was so flattened that almost no air could pass through the left nasal nare. The nasal turbinates on both sides were markedly congested and very livid. The pharynx was slightly reddened and there was a thick postnasal drip. The larnyx was negative. All other physical findings were essentially negative. The complete blood count was within normal limits, eosinophiles 2 per cent. The urine was negative, the serology negative. The X-ray of the chest showed an apparently healed tuberculous lesion. The corrected sedimentation rate was 8. The nasal smear showed many pus cells and one eosinophile cell on the entire slide.

The patient was skin-tested to the pollens, epidermals, dust (stock and from home and place of work), kapok, orris root, pyrethrum, tobacco and coffee. He was positive to dust and kapok. All other tests were negative.

Tissue culture surveys were made on three different occasions. He came down positive. each time to a Group A hemolytic strep. strain and type 7 Pneumococcus. He was negative to autogenous material from his nose and throat.

It was our belief, however, that no therapeutic result could be obtained without his mechanical obstruction being attended to first. He was advised to submit to surgery. This he refused to do, so he was experimentally put on a program of desensitization with the filtrates to which he had been found positive. He got a mild focal reaction on his first dose and when he started with the 1:100,000 and 1:10,000 dilutions.

Since April 1949 the patient has had no complaints and no sinus attacks. The yellowish discharge has disappeared entirely, and the turbinates are no longer congested. Of course the obstruction persists, and we doubt whether he can breathe much through the left nostril, but he insists he is more comfortable than he has been in years. His last examination was August 6, 1949.

CONCLUSION

The above cases amply illustrate the type of cases that are suitable for this method of approach and can be expected to respond to treatment by desensitization.

What we cannot say as yet is how long the desensitization program must be continued for permanent results. In all our cases where we have discharged the patient, we are repeating their tissue culture survey every six months to determine whether they have again become hypersensitive. So far none have, but this is inconclusive because sufficient time has not yet elapsed.

There have been some investigators who maintained that when bacterial hypersensitivity was present in chronic sinusitis cases, it was on a secondary basis. This contention is no longer tenable as proved by cases such as these, where the symptoms disappeared completely when treated solely by bacterial desensitization.

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Psychiatric Aspects of Medicine

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THE triumphs of modern medicine are based chiefly on the vision and pioneering work of Lavoisier, Virchow, Pasteur, and their successors— on chemistry, physiology, cellular pathology and bacteriology. The body has been conceived of as a machine built of cells and differentiated cells grouped as organs. Damage to cells impaired function, and symptoms and disease resulted. Medicine has been preoccupied, as science in general, with things seen, felt, heard and touched. With technological refinements, measurements and quantities have been emphasied. Laboratory medicine has increased our penetration into the mysteries of disease and immeasurably enhanced our therapeutic techniques and effectiveness.

However, man, the biological organism considered merely as a series of organs or systems functioning according to certain chemical and physiological principles of organization, leaves out of account certain factors of activation and integration that must be considered if we are to understand behavior more adequately. There are certain drives, urges or motivations, which appear as activities of the total organism functioning as a unit, not as a function of any particular set of organs or systems. These forces which drive and motivate us, subjectively perceived, are the emotions—and the three basic feelings are love, hate and fear. The life of the individual personality consists in expressing and satisfying these urges or forces in accordance with one's social training or conditioning, which appears as another guiding system within us in the form of conscience and ideals. Conflicts between the instinctive-emotional forces and the social forces produce stresses or tensions. The expression of these tensions whether in the physiology, the thought processes or in overt social behavior is the province of psychiatric study.

Freud spoke of the area of the emotional forces as the id, and that of the social forces as the super-ego. The ego may be thought of as the conscious, perceptive, intellectual functions which help in the conscious adjustment to the environment. This division of the personality into three guiding sets of functions is helpful from the point of view of the etiology of so-called psychiatric disorders and also for therapy. If the chief sources of tensions are conflicts between the feelings and social training (the guiding principles, attitudes or expectations absorbed unwittingly from our parents in the early years of life), then these tensions arise automatically, involuntarily or unconsciously, as the result of forces within us. The tensions (or symptoms) are not deliberately willed by our conscious reasoning. Therefore, the area of responsibility is markedly limited, and blaming the patient, reasoning and arguing with him have little effect therapeutically. The areas of primary disturbance is not in the intellect and ideas, but in the feelings.

The Author

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PHYSIOLOGY AND PSYCHIATRY

Modern psychiatry rests to a great extent on the work of three men: Cannon, Pavlov, Freud. The importance of the emotions and their effect on the physiology of the organism was brilliantly elucidated by Walter Cannon. The organization of responses and the conditions of learning were ingeniously worked out by Pavlov in his studies on the conditioned reflex. The effects of conditioning or training, both parental and social, on the development of the human personality were the contribution of Freud. In therapy one studies the origin, development and effects of emotional relationships to people, the exaggerations, displacements, ramifications, and handicaps of intense emotions, the defenses against them, and one tries to release the patient from their crippling effects.

Cannon really formed the bridge between physiology, medicine and psychiatry. He showed that emotions disturb the physiology in definite, measurable ways. Psychiatry is studying the effect not of transitory emotions, but the effect of intense, persistent, chronic emotions which disturb not only the physiological homeostasis, but the intellectual and behavioral equilibrium of the individual. Persistent, intense emotions certainly produce symptoms, probably some medical diseases, delay healing, prolong convales-

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cence in medical conditions, and certainly cause well-definied psychiatric disorders. Feelings, emotions, drives, with their associated impulses, thoughts, phantasies, influence the function of the body in certain types of illness. The changes produced, the dysfunctions, are in some instances the disease. Thus psychiatry deals primarily with feelings, which are tension or energies seeking outlet.

PSYCHIATRIC TERMINOLOGY

Psychiatric terminology and classification are needlessly difficult and esoteric. Their semantics create mystery. They can and should develop a homespun terminology. A psychoneurosis is an emotional condition which interferes with effectiveness, satisfaction and happiness. A psychosis is an emotional condition of an intensity which makes it impossible to work and get along with others. In psychoneurosis the Social Forces in the personality have difficulty in controlling the emotional intensities. In psychosis the Emotional Forces—the savage brute instinctive forces—overwhelm the Social Forces. The chief areas of manifestation or outlet for the emotional forces can be used as a basis of practical classification. Physiological tension states can adequately include hysteria, neurasthenia, and psychosomatic conditions. Hyperemotional tension states include anxiety states, manic-depressive conditions and involutional states. Distorted emotional tension states, where emotions are inappropriate, distorted, misplaced, projected, comprehend the schizophrenias.

Oppressive-sensitive tension states include the paranoid conditions, where people are easily hurt, feel imposed on, are jealous, misinterpret aggression, feel persecuted. Obsessive-phobic tension states include those conditons where repetitive processes predominate, where there are substitutions and displacements, reaction formations, compulsions, rituals and phobias. Tension states with organic disease include the confusions due to physical disease. Sociological tension states include the tension states associated with difficulties in social conformity. Psychopathic personality belongs here; also delinquency in children. Effort or adjustment tension states comprehend the character neuroses where the personality does not have adequate resources to meet problems and situations effectively—for example, the passive, dependent personality or the chronic aggressive personality. Situational tension states include tensions reactive to unusually difficult or trying environmental stresses. The use of such a terminology indicates the practical down-to-earth basic nature of psychiatry, helps to make its concepts understandable to the man in the street and to one's medical colleagues, and helps dissipate much of the mystery and fear that attaches needlessly to psychiatry as a result of its difficult and Greek terminology.

THE CAUSES OF DISEASE

Medicine broadly is the study of the nature of disease and its treatment. Disease is disease, disability, disorder, dysfunction—whether in the body or mind or in their inter-relations. The causes of disease in medicine and surgery are: heredity, defective structure or development, physical-chemical-toxic agents, trauma, infection, exhaustion, tumor or degeneration. In psychiatry etiological factors are: situations, stresses, experiences, disordered personalities, difficulties in inter-personal relationships, feelings or emotions.

Emotions can (functionally and sometimes structionally or psychosomatically) disorganize, dissociate, disintegrate bodily function with trembling, in-coordination, hyperactivity, weakness, paralysis and pain. Emotions can disorganize activity of the mind or personality with excessive, persistent anxiety and fear; resentment or hostility, discouragement and depression; suspicion, jealousy and hate; dependency, lack of initiative and apathy; and amnesias, delusions and hallucinations.

One of the difficulties with psychiatry, one of its handicaps, is that emotions can cause the same symptoms and disorders as physical, medical, structural disease—as infection, tumor, trauma or degenerative disease. Doctors have been trained to look for what they can touch, see, hear, weigh and measure. They have often overlooked factors just as real—the feelings, desires, personal relationships or social feelings, which can be apprehended not by the five senses but by understanding. Thus often doctors have attributed pains, weakness, heart discomforts, worry about ulcers, cancer and brain tumors, to the imagination rather than to the real causes in the stresses and pains of the personality—the unconscious anxieties, hostilities, guilts, dependencies, resentments and thwarted love, drives and ambitions. Benjamin Franklin said, pain is pain and pleasure is pleasure, whether real or imaginary. Fortunately the recent study of psychosomatic medicine is dissipating the imagination as a supposed cause of many worries and illnesses, by extending research into the ramification and conversion of emotion into physiological disturbances.

Restlessness, irritability, loss of concentration, ineffective work can be caused on the one hand by arteriosclerosis, renal disease, hypertension, multiple sclerosis; or by financial worry, frustrated ambition, the aggressiveness of the spoiled child, or melancholia. Weakness and paralysis can be caused by tumor and multiple sclerosis, or by discouragement, disappointment, worry and fear. Headache and vomiting can be caused

by tumor, encephalitis, hypertension, or by strain, frustration, depression. A girl was sent to the Psychiatric Clinic for headache and vomiting. This followed an abortion for an illegitimate pregnancy. The shame and remorse were supposed to be causing the physiological symptoms. In three weeks she was dead, of a tumor of the brain stem. This shows the difficulty of differential diagnosis at times.

Temper tantrums, enuresis, lying, mistakes in arithmetic, are not brain disease in children. They are ineffective responses to environmental situations, defective development of the personality, unsatisfactory training or conditioning. Thus many, probably the majority of psychoneuroses and many psychoses are not brain disease or disease of the nervous system. They are the results of unfortunate, often chance, unconscious unwholesome conditioning, with the development of exaggerated, intense emotional habits, which hinder effective functioning and living.

Psychiatric therapy in the past has been chiefly expectant or custodial, interminable or exorbitant in time and money. Modern therapy is dynamic and often effective, rather than expectant. It requires work with the individual patient and takes time. That is one of the great handicaps of psychiatric therapy. But time is an important factor in conditioning which lies at the source of psychiatric conditions. If it takes fifteen, twenty or thirty years of conditioning to produce the disability, it is not surprising that it requires weeks, months or several years to supply the corrective emotional experiences or reconditioning that constitute psychiatric therapy—conditioning requires time.

EXPERIMENTAL NEUROSES

The production of experimental neuroses in animals and experimental physiology have formed the background of much of our psychiatric and psychosomatic knowledge. Time is required for conditioning. Liddell found that if electric stimulation was given to a sheep's foot, with a metronome beating as a conditioning stimulus, the animal could perform satisfactorily at intervals up to thirty seconds. It stood quietly before and after the shock was delivered. If however, the interval was thirty seconds or more a profound disturbance resulted. The animal became tense and restless. It moved its leg when the metronome didn't beat; when the metronome did beat it often flexed its leg with each beat. It resisted going to the pen. It was restless in the pen. It was withdrawn and often cowered. It was submissive in attack. The pulse was rapid and often irregular. It suffered from a neurosis as a result of training. Kept in the laboratory for one and one-half years the condition improved, but if tests were then resumed, the neurosis returned. In one instance the neurosis remained till death after thirteen years.

Time and experience are thus conditions in the development of neurosis and must be taken into account in treatment. It took a young doctor one and one-half years to recognize his tendency to be dependent. It required seven years for a patient to be able to utter the words pregnancy or baby, she was so afraid of them. It took a salesman three years to be in any way critical of his father, he had so much guilt as a result of his hostility toward him.

A normal, friendly, cooperative chimpanzee can be made emotionally upset by complicating a food testing situation so that she develops temper tantrums, rolls on the floor in anger (as an Army colonel did when his daughter became engaged to a man of whom he disapproved) refused to go into the cage, beat the gate in anger, frequently defecated and urinated, which are signs of diffuse sympathetic discharge. After removal of both frontal lobes, in the test situation the animal is not upset, not emotional no matter how many mistakes are made.

After the removal of the frontal lobes for a tumor in a 40-year-old man, his character changed from a quiet, submissive person to a facetious, euphoric, childish one, with frequent outbursts of anger.

Stimulaton of the sympathetic or parasympathetic nervous systems produce characteristic physiologic changes, which similarly are often seen in the neuroses. Alexander in his studies on the relationships between emotions and physiology believes that aggressive emotional impulses tend to find outlet chiefly through the sympathetic pathways, as in hypertension, while regressive impulses tend to discharge through the parasympathetics, as when strong dependency feelings and longings affect the stomach.

The relation of metabolism to feelings is well known. In myxoedema there is a drop of performance; feelings of inadequacy, dullness and depression are not infrequent. In hyperthyroidism there is emotional lability, with frequent feelings of irritability, anxiety and guilt. When medical students were exposed to an atmosphere of diminished oxygen tension there was impairment of emotional control with elation and flightiness. Psychoneurotics similarly exposed behaved like hypomanics, with marked lack of emotional control, great increase in self-esteem and sexual preoccupation.

The hypothalamus plays an important role in vegetative innervation and regulation. Pathology in the hypothalamus not only affects the physiology of the body but the emotional reactions, for example, aggressiveness. Stimulation of the anterior nuclei innervates the parasympathetic, while stimulation of the posterior

nuclei stimulates sympathetic discharge. Tumors stimulating the anterior nuclei have been reported as producing excitement and flight of ideas, while those stimulating the posterior nuclei lead to indifference, depression and lethargy.

If the brain is sectioned above the hypothalamus in cats, spasms of ragelike behavior ensue. Rubbing the cat will produce arching of the back, clawing, lashing of the tail, snarling, increased breathing, salivation, and dilation of the pupils.

PSYCHOSOMATIC MEDICINE

Cushing long ago made observations of importance for psychosomatic medicine when he found gastric ulcers appearing after certain brain operations.

Wolff has shown that anger produces engorgement of the blood vessels of the stomach, while fear produces palor of the mucosa. He has also demonstrated a drop of 13 degrees C in the finger temperatures when patients were discussing unpleasant emotional subjects. This is important etiologically because if such disturbed circulation can result from emotion, it is not difficult to conceive of permanent nutritional and structural alterations arising from prolonged emotional tensions over the course of years. These observations afford hints as to therapy, namely affording release of these emotional tensions in an atmosphere of patient, sympathetic, understanding, accepting, consideration and discussion of the patient's feelings.

The work of Cushing, Cannon, Bard, Gant, Fulton and Liddell thus formed the physiological background for psychosomatic medicine. Alexander and his co-workers, following Freud and Pavlov, have carried this work further and investigated the emotions and feelings involved or related to certain clinical medical conditions. This is the meaning of psychosomatic medicine, the investigation of the interaction and interdependence of emotion and bodily function. Psychosomatic medicine is not something entirely new, for the intelligent general practitioner has always considered the feelings and background of his patients in making the diagnosis and planning treatment. Psychosomatic medicine merely aims at discovering and making more precise the nature of these relationships. Psychosomatic medicine is better thought of not as a new specialty but as a psychosomatic approach to the problems encountered in all medical specialties (Dunbar).

What are some of these emotional correlations? —whether casual or contributing, remains to be worked out. From birth, eating is related to emotions. Feeding is closely associated with love and maternal care. Receiving food may become associated with taking and wanting other things and may lead to impulses of greed and possessiveness. Biting may become an expression of hostility. If hostility is strong, guilt may appear and motivate eating disturbances, as is frequently seen in melancholia. Hostility and guilt may manifest themselves in anorexia, unwillingness or inability to eat. Eating may be a substitute satisfaction for the desire for attention, support, consideration and love. Bulimia and obesity frequently seem to have such origins. In anorexia nervosa certain hostile feelings may be rejected because of shame and guilt and because they are so closely associated with eating, food cannot be taken. Repulsion against food is not infrequently seen as a substitution for repulsion toward sex. Hostile impulses may become associated with eating and biting. They become inhibited because of guilt and shame, and food is refused. Fasting is a traditional mode of atonement and hunger-strikes express hostility.

Emotional disturbances cause loss of appetite and vomiting. Rejection of certain feelings and impulses because of fear and guilt often lead to these reactions. Emotional tension causes the familiar lump in the throat and cardiospasm.

Peptic ulcers occur in the driving, ambitious, worrying men of ability. They have persistent drives to overcome obstacles. Alexander has found in these people strong cravings for emotional support, care, dependence and love. These feelings and desires are closely associated with stomach functions, so that they stimulate the stomach to hypersecretion and hypermotility (as the desire for food does) when these feelings are continually frustrated. They act as constant stimuli to the gastric mucosa, which finally breaks down with the formation of an ulcer.

Elimination early in life becomes associated with emotions. This function early becomes associated with feelings of pride and power, accomplishment, giving and yielding, or with resistance to training and authority, and the development of hostility. Diarrhea is frequently associated with fear. When pregnancy is feared, diarrhea may appear as an emotional substitute. Colitis is often associated with feelings of resentment and hostility. The emotional attitude is expressed by the bowel. A young lady of thirty-five had to move away from her parents and home environment when her husband changed his work. Her anger and hostility were expressed in a prolonged severe case of colitis.

The heart has long been called the organ of anxiety. It has been held by romanticists to be the seat of the emotions. It leaps for joy and is broken by grief. It palpitates for love and stops in terror. Fear drives it into the mouth and depression into the feet. It throbs in sympathy, flutters in modesty, beats strongly in courage. It is of gold in honesty. It aches

and pains in anger and frustration. Where there is lack of sympathy, we say, one has no heart or heart is cold.

Chest pains and heart pains are reported in patients when there are strongly repressed hostile and aggressive impulses. Palpitation and extra-systoles have been observed when strongly aggressive and competitive impulses have been mobilized. Cardiac neuroses are apparently increasing, which is attributed to the added stress of modern living. In hypertension hostility and aggression are intense and chronic but inhibited. The anger is often rebelliousness against domination and protest against authority and responsibility.

In asthma there is fear of separation or estrangement from a mother or mother substitute. The personality traits of asthmatics often show over-anxiety, lack of self-confidence, or a clinging dependence on parents or parental substitutes, which is often a result of parental over-solicitude. Temptations and threats to security and dependence seem to precipitate attacks. There is a relationship to anxiety and crying—weeping changing to wheezing. Dreams and phantasies show wishes to be secure and protected, not as in gastro-intestinal cases where the wishes are to be fed. Threatened by too sudden fear of separation or estrangement the cry as a child for its mother is repressed and replaced by an asthmatic attack.

Laryngitis may occur when hostile verbal attacks are inhibited. There may be an emotional factor in the common cold. Saul found a frustration of wishes for love, protection and dependence, with repression of the consequent anger and hostility, at the time colds developed.

Many skin diseases appear to be related to pent up anger and rage. People are "burnt-up" over some situation and this expresses itself in the disturbed physiology and eruptions of the skin.

Emotions are important in arthritis and neuralgia. A woman of 35 was disabled with pain in the back and asthenia for eight years. She had two operations and had worn a brace for months. She had been a bed patient for one and one-half years. Physical and laboratory studies were negative except for mild arthritic changes in the spine. The usual medical and orthopedic procedures were of no avail. The patient was seen in interviews of thirty minutes each, five times a week. The physician in the main was passive in the therapeutic conferences. The patient was encouraged to talk of anything that came to mind and to express herself freely. Stimulating questions were asked, to bring relevant considerations and feelings to consciousness and expression. Direction, reassurance and suggestions were given as sparingly as possible. Gradually over the course of months, emotions of anger and resentment came to the fore and assumed unusual proportions. They were often expressed violently in words, gestures and dramatizations. There were acts of destructiveness. It became clear that the emotions of resentment and hate toward a rejecting, neglecting, unfaithful father and a driving, restricting, meticulous, rigid mother, in childhood, repressed over the course of years, and the hostility toward her husband, had permeated into her bodily system and with their tensions had caused her pains and weakness. With the release of these emotions by verbalization, gestures and dramatic expression, the weakness and pain disappeared, health and normal social life returned. This case shows some important points in psychotherapy and treatment. There was little authoritative direction. There was no exhortation and no reasoning. When the malignant emotional tensions were released, recovery took place, and reason and self-direction spontaneously reasserted themselves. It was the attitude of the physician toward the patient, what he allowed and encouraged to go on in the therapeutic experience, that was important. This case illustrates another point—the things a patient does not talk about at first are often more important than what he talks about. Thus time and patience are required until the violent emotional tensions press forward and become verbalized.

PSYCHOTHERAPY

This brings us to the therapy of psychiatric conditions. Psychotherapy is not an intellectual exercise. It is not a transference of ideas from doctor to patient. It is not merely the development of insight. It is not an argument. It is not exhortation or a lesson in morality. It is not a battle of wills. It is not an opportunity for the doctor with his superior wisdom to impose his ideas on the patient, make him feel inferior or humiliated. It is not an occasion for the doctor to express his anger at the patient because of his own frustration in treating the patient successfully.

Psychotherapy is an experience, and as such it is a process of conditioning and growth. Like growth much of it goes on unconsciously and automatically. An automatic readjustment of the emotional and social forces (which have been conflicting and in tension) takes place. Psychotherapy is a social experience, that is, a relationship with a doctor who wants to help his patient. It is an experience, again I repeat, not an intellectual exercise, in which the doctor's attitudes toward his patient are the most important levers of therapy. The doctor should bear in mind certain needs of all people: the need for new experience; for security; for respect and a feeling of individuality; and for respon-

siveness and understanding from another human being.

Security is given by accepting the patient for treatment, by giving him the support and protection implied by a regular plan of appointments—something to look forward to. The physician is not critical, contradicting, and is not trying to force the patient to change. He shows interest, patience and consideration.

Respect is given by affording the patient a feeling of individuality and worth. He accepts the patient for what he is, with all his annoyances and immaturities. He allows freedom of expression without condemnation or criticism. He is tolerant and permissive. He recognizes areas of responsibility and lack of responsibility (due to chance, training, past experience) in the origin of the patient's condition.

The physician shows responsiveness to the patient, and makes efforts to understand what forces are at work in his patient. These efforts to understand are often more important therapeutically than actual understanding. Therefore, general practitioners can do good psychotherapy without a profound knowledge of psychopathology. This responsiveness plus the other attitudes enable the patient to share his thoughts and feelings. This affords an experience of participation and togetherness which is important in therapy.

With the exhibition of such attitudes the patient will gradually identify with the doctor. The doctor has a scientific, objective approach to overwhelming situations and conditions. He is not overwhelmed. He knows what to do. He has plans of attack, through asking relevant questions and exhibiting certain attitudes. The patient absorbs this point of view through identification with the doctor, and gradually learns to meet problems and difficulties by asking himself the same questions, and using the trial and error approach, with repetition and practice.

The doctor sets the stage where his attitudes permit the release of malignant emotional tensions. When understanding of the complexities of the human organism is so much beyond our ken, there is place for humility.

But getting well is more important than complete understanding of all the causes of the illness. In this connection, may I close with a quotation from Lord Grey: "Nothing so predisposes men to understand as making them feel they are understood."

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The Story Behind The Word:

Some Interesting Origins of Medical Terms

Esophagus—A contraction and simplification of the Greek word "oesophagus" or the gullet. It is derived from the Greek words "oiso," I shall bear or carry for another, and "phagein" to eat.

Intestine—From the Latin word "intestinus" meaning inward or hidden which in turn comes from the Latin "intus" or within.

Jejunum—This name comes from the Latin word "jejunus" meaning fasting, empty or dry. This portion of the small intestine was so named by the early anatomists because it was always found empty and hence they literally named it the "empty intestine."

Ileum—The ileum or "twisted intestine" derives its name from the Greek term meaning to "roll" and was so called from its peristaltic movements.

Cell—Robert Hook (1665) a botanist first used this term to designate the minute cavities he observed in the microscopic structure of cork. The word cell is from the Latin "cella" and Hook used the name because of the fancied resemblance of the cork structure to the monastic cells or cubicles used by the monks in monastaries.

Dropsy—This term is a shortening or corruption of the old French term "hydropisie" which in turn comes from the Greek word "hydropikos" or relating to water—from the Greek "hudor" or "hydro" meaning water.

Rash—This term is derived from the German word "rasch," meaning quick or impetuous and also the Danish word "rask," meaning quick. Hence used medically to designate a rushing or sudden breaking out of an eruption on the skin.

Anatomy—Literally "a cutting up." This term is derived from the Greek "anatome" or dissection, which in turn is composed of the Greek words "ana" or up and "tome" a cutting.

—Harry Wain, M. D., Mansfield, Ohio.

The Fourth International Neurological Congress*

JOSEPH L. FETTERMAN, M.D.

THE Fourth International Neurological Congress was held in Paris, France, September 5 to September 10, 1949. The meeting provided a scientific core surrounded by social events and the historic sights of this famous city.

Paris is a place of living beauty enhanced by the footprints and handiwork of history. In its center is the River Seine crossed by thirty-two bridges whose design and form invite seeing as well as crossing. For here is a river whose banks have individual names and upon whose banks are attached rectangular wooden shelves, the popular and famous book stalls. Readers and traders of books and magazines and pictures come to browse, to chat, to carry on a miniature exchange in literature. It seems as though Frenchmen do not discard books and magazines which they have read, they turn them in for others to enjoy. Etchings and lithographs and paintings add attraction and interest to the wares of the book stalls. Here are the outlets for many painters who work along the Seine, sketching the ancient Notre Dame Cathedral and the bridges nearby.

IDEAL LOCALE

Extending parallel to the river or arching like spokes in different directions are wide, spacious boulevards. There is ample room for vehicles, as well as for rows of trees, then broad sidewalks and numerous shops. In the endless succession of attractive shop windows are perfumes and linens, jewels and dresses, and pictures and statues. On the corners are the cafes whose tables fan out upon the sidewalks, tables where Frenchmen sit and sip black coffee and chat as they leisurely watch the world go by. It seemed as though Frenchmen have three common escapes: reading, painting, and sitting at sidewalk cafes discussing life, liberty, and the pursuit of sexual happiness.

Boulevards and avenues join each other in large, beautiful squares. These are referred to as "Place" and are often named after an event, person, or building. For example, the Place de L' Opera is a rectangular area extending from the beautiful National Opera House and at which some six famous streets join. The Place de La Concorde is a more tremendous circular area in whose center are an obelisk and a gorgeous fountain while marble banisters, attractive bridges, and gardens surround this square. Its name means place of peace, a term that may represent a compensation for its use during the French Revolution as a site for the bloody spectacle of the guillotine. For in this now beautiful and peaceful square thousands of Parisians gloated and shivered when the delicate Marie Antoinette and her Louis XVI lost their heads as did thousands of less royal followers.

*A Reportorial Review by Dr. Fetterman, Cleveland, Ohio. Submitted November 4, 1949.

The Author

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ARCHITECTURE TRIUMPHS

Paris is full of buildings which combine beauty, utility, and history. In the outskirts of the city is the palace of Versailles where Louis XIV spent his childhood and then during his long and famous rule told the world, "L'Etat C'est moi." (I am the state.) In this beautiful building the Versailles Treaty was signed, later to be ignored and trampled upon. In the center of Paris at the Place de L'Etoile is the famous Arch of Triumph at whose base lies the remains of the Unknown Soldier for whom a flame burns constantly. Nearby is the Louvre, an immense ex-palace now housing art treasures of the world. Here among other paintings the Mona Lisa hangs demurely and pensively, not at all jealous because more visitors seek the statue of Venus de Milo. The crowds study the face and form and drapes of Venus, some with open admiration and others with such jealous phrases as "she is a little too well developed in certain parts." Venus stands unruffled, armless, with unrivaled dignity and beauty.

Across the Seine from the Louvre is the 980 foot Eifel Tower, a tapering, steel structure, conspicuous because of its unique design and because there are no other relatively tall buildings. Visitors gape and arch their necks to see this unusual building which now serves usefully as a radio transmitting station and as a guide to aviators. Close by is the vast Hotel des Invalides, built by Louis XIV as a home for disabled veterans. It is so large and extensive that it once housed seven thousand men. Then in the 1830's the remains of Napoleon was placed in a beautiful section of this building, known as the Tomb of Napoleon.

In this atmosphere of beauty and culture were

many schools and hospitals including the Sorbonne University, the historically famous Hotel Dieu and of course the Ecole de Medicine. This School of Medicine consists of two large and beautiful buildings, each on one side of a small street, once famous as the hotbed of the French Revolution. Today these buildings are devoted to the welfare of mankind. On one side are the lecture halls named after some famous French doctor, such as Amphitheatre Vulpian and Salle Pasteur. The other building, in the center of which is a lovely courtyard with a fountain and shrubbery and trees, contains the laboratories of the school.

OHIOANS PRESENT

In the two buildings of the Ecole de Medicine were held the meetings of the Congress. The attendance was large and included neurologists from practically every country in the world. A list of the speakers and their countries resembles the roster of the United Nations. It is interesting to mention that several representatives from Soviet Russia were listed on the program but none appeared in the meeting. The United States had the largest representation, 180 members; Great Britain was well represented as were the Scandinavian countries, Holland, Belgium, Germany, Portugal, Spain, India, Israel, South Africa, and the countries in North and South America. Of local interest, we may mention that three Ohioans were present, Dr. I. Mark Scheinker of Cincinnati; Dr. Laurence M. Weinberger of Akron; and the author.

The program was divided into general meetings held in the mornings and many smaller limited sessions in the afternoons. Each morning session dealt with one assigned topic to which selected, eminent speakers and discussants contributed. There was ample time for a rather complete presentation. The subject matter, which was covered in the several morning sessions, included Electroencephalography, Anatomy and Physiology of the Thalamus, Virus Diseases of the Central Nervous System, and the Neurosurgery of Pain. Wilder Penfield and Herbert Jasper (Canada) took a leading role in the Electroencephalography session. W. E. Le Gros Clark (England) and W. R. Hess (Switzerland), Ludo Van Bogaert (Belgium), and J. L. Hermitte presented the papers dealing with the Anatomy and Physiology of the Thalamus. The subject of Virus Diseases was formally presented by A. B. Sabin (U. S. A.) and W. McD. Hammon (U. S. A.), Sven Gard (Sweden), and P. Lépine (France). The discussion on Surgery of Pain was introduced by O. Sjoquist (Sweden), H. Krayenbuhl, and W. Stoll (Switzerland), R. Leriche (France), and G. F. Rowbotham (England). These formal presentations were followed by ample discussion from the floor. The papers were delivered in the language of the speaker. The listener who did not understand the language was helped by an abstract of the paper in the printed program and at some sessions by translation.

DIVERSIFIED PRESENTATIONS

The afternoon sessions were held simultaneously in seven different halls. Each speaker was allowed but ten minutes to deliver his "communication." Speakers were allowed to choose their own subjects and as a rule presented material which was a condensed review of years of study. Generally, topics were grouped according to one major theme but at some sessions the lectures dealt with widely diversified material. In all, there were over one hundred and fifty papers at these sessions. This rich assortment of neurologic material was not presented without some confusion and difficulty. At times the program was not accurately followed and a visitor might hasten from one hall to another only to find that the lecture which he desired to hear had already been given. There was, of course, the problem of language comprehension and occasionally repetition of subject matter.

The papers covered such subjects as Central Nervous System Lues, Epilepsy, Multiple Sclerosis, Traumatic Disorders, Diagnostic Procedures, and Therapeutic Techniques. The material was of a highly scientific order and of considerable clinical interest. However, most of the audience did not bring home new therapeutic measures of great value.

EXHIBITS

In addition to the scientific papers there were several fine exhibits. I was particularly impressed by the exhibit dealing with the History of Neurology presented by Webb Haymaker under the auspices of the Army Institute of Pathology and the Army Medical Library. This exhibit consisted of the photographs of the leading neurologists of the world, living and dead, and copies of the original material such as articles and books which they had published. It is planned to gather this most interesting exhibit into a book form. I am confident that neurologists throughout the world will be eager for the publication of this project.

Although the major interest of this meeting was scientific there were several social functions. The Paris Neurologic Society was the host at a large reception for all the guests. Later the visitors received a warm welcome from Pierre De Gaulle in the ancient but still elegant and beautiful Hotel De Ville (City Hall) and an elaborate banquet was also held—outstanding because there were practically no speeches. Several sight-seeing tours were arranged.

We who attended the meetings found in the science of the sessions, the sights of Paris and the socialization from fellow-neurologists from all over the world a reward which more than justified our visit to Europe.

Failures in Electroshock Therapy

CHARLES LANDIS ANDERSON, M. D.

The Author

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ELEVEN years have elapsed since Cerletti and Bini first gave to psychiatry a new technique of electrically induced convulsive therapy for the treatment of mental disease. It has been nine years since this form of treatment was first used in the United States. Electroshock has become an accepted form of treatment for certain mental diseases, and its usefulness in those conditions is seldom seriously challenged. Whereas a few years ago it took considerable salesmanship on the part of the psychiatrist to persuade relatives that it was safe and therapeutically effective to treat a typical depression with electroshock, now we often encounter patients and their relatives asking for electroshock as a treatment for almost any type of nervous disorder. With such wide acceptance of this treatment by the medical profession and the general public, there has arisen a greater need for discrimination in the selection of cases to be treated by electroshock.

The purpose of this article is to record certain clinical impressions gained while treating 1,200 patients with 16,000 electroshocks during the past eight years at the Harding Sanitarium, and to invite the comments and suggestions of our colleagues who are dealing with the same problems. Emphasis will be placed upon failures with the hope that further study may reduce their incidence.

The following brief classification will be used as an outline for discussion:

1. Conditions in which electroshock is the treatment of choice.
2. Conditions in which electroshock is of no value and should not be used.
3. Conditions in which there is disagreement regarding the value of electroshock.
4. Inadequately treated cases.
5. Cases in which shock is indicated, but which fail to respond in spite of adequate treatment.

In this article, failure is considered to include cases which responded only slightly or not at all, and cases which responded but soon relapsed. Those who obtained a remission from their illness and more than a year later again became ill are not counted as failures.

CONDITIONS IN WHICH ELECTROSHOCK IS INDICATED

The affective disorders are generally considered to respond particularly well to electroshock. This is especially true of the typical depressions, both of the manic-depressive and involutional melancholia types. Failures in this group are relatively infrequent. Cases of agitated depression often respond well, but failure is somewhat more likely. Gross somatic and nihilistic delusions make the prognosis poorer.

A number of other conditions, such as manic states and involutional paranoid reactions, probably should be placed here, but as there is some difference of opinion about them, they will be discussed below.

CONDITIONS IN WHICH ELECTROSHOCK IS NOT INDICATED

Among the psychoneurotic reactions are many difficult cases that respond poorly to all forms of therapy, often because the patient has little to gain from abandoning his illness. To the overworked physician and the harried family, a "short-cut"[4] treatment, in which the patient is not required to be an active participant, may offer promise of welcome relief. But shock applied to such conditions is almost always doomed to failure. Anxiety state does not respond well to electroshock; obsessive-compulsive, hypochondriasis, and neurasthenia are not benefited. All these conditions may seem better temporarily while confusion and euphoria resulting from the treatment becloud the picture, but within a few weeks at most it will become apparent that nothing has been accomplished. The patient may be even worse than before, perhaps because his hopes for an easy cure failed to materialize.

Electroshock when employed to treat various psychosomatic manifestations, such as hypertension, neurodermatitis, asthma, peptic ulcer, etc., is unlikely to accomplish any good. However, if hypertension is part of the picture of an agitated depression, the pressure will fall, often to normal, as the depression is relieved

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by treatment. In our experience psychosomatic problems not associated with psychoses have not been benefited by electroshock.

Other conditions which will result in failure if treated with shock therapy include chronic alcoholism, psychopathic personality, and homosexuality.

CONDITIONS IN WHICH THE VALUE OF ELECTROSHOCK IS NOT SETTLED

Some authorities have expressed the opinion that electroshock is not indicated in the treatment of manic-depressive, manic states.[1] In our experience this seems to be true regarding hypomanic cases, who can absorb a large number of treatments without showing any appreciable improvement. Fortunately, in the more highly disturbed cases, where it is imperative to quiet the patient to save him from exhaustion, electroshock is very useful. It is necessary, however, to give a large number of shocks within a short time, as many as four or more shocks a day for the first few days, and daily for some time thereafter. Under such intensive treatment we have obtained about as good results with manics as with depressed cases. During the past year we have used coramine with electroshock as described by Fabing,[2] and in the small number thus treated our experience has paralleled his.

The treatment of the circular and mixed types of manic-depressive psychosis has, in our experience, proved disappointing. While not to be considered a failure of treatment, electroshock in bringing about a remission of a particular attack has not prevented subsequent attacks. Recently reported work by Geoghegan and Stevenson[3] indicates that in manic-depressive cases, subsequent attacks can be prevented for an apparently indefinite period by administering prophylactically one shock a month.

Reactive depression, though classed as a psychoneurotic reaction, often responds well to electroshock,[5] especially when the personality had previously been adequate and the precipitating factor was strong. A frequent example during the war was the reaction of a mother or a wife to news of the death of a serviceman.

Electroshock is useful as a means of initiating the treatment of conversion hysteria, somewhat as intravenous barbiturates are used. This should be followed up with psychotherapy after the immediate symptoms have been relieved and some confidence in the physician established. Where the conversion symptoms involved the function of locomotion, we were able with shock therapy to demonstrate to the patient his ability to walk better than we could with intravenous barbiturates, which made the patient dizzy and thereby sometimes unable to walk. It should be emphasized that the use of shock treatments alone will end in failure.[5]

Postpartum psychoses are said by some not to be benefited by electroshock.[1] The following case summary is typical of our experience. A 30-year-old white female, following the birth of her second child, developed an acute schizophrenic excitement. She was delusional, hallucinated, destructive, noisy, and not eating or sleeping. After a few days she became mute and immobile. After eleven shocks she was so improved that her family considered her recovered. However, within a few days she began to relapse. Further treatment was given according to her clinical condition. Most of the time she was able to be at home and come in for shocks at fairly regular intervals. Over a period of six months she received 41 electroshocks. For the past four years she has remained well. While shock therapy apparently does not greatly shorten the period of illness, it does aid materially in the management of the patient, so that she can often remain at home rather than spend several months continuously in a mental institution.

Certain patients suffering from a psychotic depression, and ill enough to make suicide a definite hazard, fail to respond more than temporarily to adequate courses of electroshock. Often it will be found that such individuals had been suffering from neurotic complaints for years before the depression set in. They were basically anxious, dependent people, often with much guilt and unconscious hostility. Insomnia may have been present for years. The depression seemed to be secondary to the long-continued neurosis. For example, we have had under our care off and on for the past five years a 60-year-old married woman who developed an anxiety neurosis about four weeks following a hysterectomy. The persistent anxiety with the associated physical phenomena caused her such distress and so restricted her life that she became depressed, emotional, and suicidal. We have given her four courses of shock treatment, totaling 46 in all. The temporary improvement was always followed by a relapse characterized by a return of her anxiety, discomfort, and then depression. She remains in the same condition today.

Involutional paranoid reactions do not respond as well to electroshock as do involutional depressions. However, with little else to offer these psychotic cases, it would seem that this form of therapy should be given an intensive trial. Those paranoids who do recover need a longer series of shocks than do the depressed involutionals.

Such a case is a 50-year-old single businesswoman. She had always been of a rigid, perfectionistic make-up, had not married because she

couldn't find the man that suited her. Her work was always highly satisfactory. She carried much heavier responsibilities than her position or salary would warrant; in fact, the president of the organization was dependent upon her to make out all financial reports. She resented the lack of recognition, though she liked the work. She had little to interest her outside of her work, she didn't make friends easily, and she was secretive about her personal affairs. More prominent than her depression were her suspiciousness and paranoid delusions, which had been present several weeks upon admission. Twelve electroshocks apparently resulted in recovery, but after a few weeks she relapsed, her paranoid delusions being more systematized than before. She received another 20 treatments and made an excellent recovery. After several months of convalescence she was able to return to work and has remained well for three years.

SCHIZOPHRENIA

Schizophrenia is responsible for more failures of electroshock therapy than any other psychiatric condition.[4] Cases with a history of a poor prepsychotic adjustment to their environment, with insidious onset of illness, long duration of symptoms, and without strong precipitating factors are almost certain to remain ill in spite of treatment. On the other hand, the schizophrenic who had made a mature psychosexual and occupational adjustment, who was reacting to strong environmental factors, and whose illness was of sudden onset, had a good chance of recovery, even before the introduction of electroshock. Such cases account for many of the dramatic recoveries seen in military life during wartime. The simple and hebephrenic cases, which usually never did make a mature adjustment to their environment and who became ill early in life get little benefit from such therapy. The majority of them in our experience have failed to recover by means of electroshock. While catatonics often respond well to shock, they tend to relapse. The paranoid often forgets his delusions only during the period of treatment. However, enough catatonics and paranoids make a recovery to justify using electroshock on those with fairly normal past histories who haven't been ill more than six months to a year, and who exhibit considerable affect.

The following case history illustrates the persistent treatment of a catatonic schizophrenic with eventual successful outcome, an eventuality that was not anticipated by her physicians. A white female, now 45 years of age, showed the first signs of mental illness in 1928. At that time she spent nine months in a private institution. For the following two or three years she appeared to be well, but in 1933 she again became mentally ill. She was continuously in a psychiatric institution from 1933 to 1942. Between April and November, 1938, she received 151 insulin coma treatments with only temporary improvement. During 1940 and 1941 she had five hypothermia treatments, each lasting from one to three days. Between July, 1941, and September, 1942, she received 60 electroshocks. After a few treatments she would appear nearly normal but relapsed a few days later. She went through recurring cycles of treatment, improvement, and relapse.

After she was transferred to the Harding Sanitarium in October, 1942, we gave her electroshocks with similar results. During the first year of treatment she had 51 shocks. In October, 1943, she became an outpatient, traveling from her home for treatments when necessary. In the spring of 1946, after she had had about 170 shocks, she began working in an office and has continued in that position until the present time. At the first sign of a relapse she was returned to the Sanitarium for another outpatient treatment. Thus she missed very little time from work. By April, 1948, she had received 267 electroshocks. During the past year she has remained apparently well without any treatment whatever. Early in our experience with this case we allowed her to relapse completely before resuming treatment. At such time she would lie on the floor nude, mute, in the fetal position, and refusing to eat or release her sphincters. Later, this picture was not seen, as we treated her upon the first sign of relapse. This patient received in all 327 electroshocks, plus 151 insulin comas, making a total of 478 shock treatments, both insulin and electric. If all schizophrenics were treated as intensively as this patient, perhaps many more of them would recover. This is in line with the claim of Wilcox that schizophrenics treated early and intensively respond as well to electroshock as to insulin coma.[5] Practical limitations of time, personnel and money often make such a routine as we have outlined impossible, however.

INADEQUATELY TREATED CASES

What constitutes adequate electroshock therapy? The number usually necessary to effect a recovery varies with the different conditions treated. Most cases would probably fall within the following range: Depression (manic-depressive or involutional), 4 to 10 shocks; manic state, 10 to 20; postpartum psychosis (which is usually a schizophrenic reaction), 20 to 40; involutional paranoid, 20 to 40; schizophrenia, 20 to 40 and more.

Oftentimes a patient is treated inadequately through no fault of the physician, but because the family is uncooperative, or the patient refuses to take more treatments. Inability to pay for a long series of treatments together

with an unwillingness to accept state hospital care may also be responsible for inadequate treatment in private practice.

FAILURE IN SPITE OF ADEQUATE TREATMENT

Not infrequently a case will fail to improve or will quickly relapse in spite of the fact that experience indicates it is the type of case that should respond readily. Sometimes the patient must return to an intolerable environment, which neutralizes all therapeutic efforts. It may be possible to educate the family to the needs of the patient, thus making the environment more attractive. The importance of adequate follow-up supervision, either by the psychiatrist or the family physician, should be kept in mind. In a questionnaire we sent to about 200 of our former electroshock patients several years ago, we learned that most of them didn't feel they had fully recovered from their mental illness until about three months after they were discharged. That three-month period of adjustment we feel is a crucial time for the patient.

Another reason for failures may be that our diagnostic acumen is still faulty and that we are giving shock to patients who should have other forms of therapy. The usual custom of trying electroshock first on schizophrenics, and if that fails using insulin coma, might be reversed, especially in the simple and hebephrenic types, where electroshock has little to offer. And then after all possible causes for failure have been explored, there will still remain a certain number who fail to respond. But such is the experience of medicine in the employment of all forms of treatment.

DISCUSSION

In order to stimulate further discussion of the problem of failures in electroshock therapy, I would like to suggest the following points: (1) A careful evaluation of each patient before electroshock is begun. In some cases, such as a typical manic-depressive depression, the diagnosis can be made readily and treatment begun at once. However, in cases where there is some doubt about the diagnosis, where the symptom picture is not exactly typical, it would be wise to have a clinical psychologist examine the patient with a battery of tests and where practicable, have the patient examined by a staff of one's psychiatric colleagues. Some patients, though cooperative, need to be hospitalized for more accurate diagnosis before treatment is instituted. (2) After a diagnosis has been arrived at and electroshock is started one should be careful to give a sufficient number of treatments, continuing to 20, 40, or even more shocks, if necessary. (3) Certain cases make more rapid progress if psychotherapy is combined with electroshock. Agreeing with Fetterman, et al.,[7] we feel that the two are not antagonistic procedures. Sometimes the psychotherapy is given on alternating days between shocks or it may be more effectively employed following the termination of electroshock. (4) Analytically oriented psychotherapy should be employed instead of electroshock in those confused symptom pictures where anxiety, guilt, and obsessive-compulsive symptoms are prominent. In the more difficult cases of this type the general psychiatrist should refer them to a properly qualified psychoanalyst. (5) In many instances the electroshock does its work, but the chance for permanent improvement is destroyed because the patient has to return to an unsatisfactory environment. It is the duty of the psychiatrist to continue to follow the patient, if possible, after he has been discharged from hospital or office treatment and assist him in creating a better environment when this is needed. There has been valid criticism of the practice of a few psychiatrists of giving the patient his shocks, taking his money, and turning him loose. (6) We must expect some failures when our chief consideration is the welfare of the patient and not the assembling of impressive statistics. Knowing this, we should continue to treat involutional paranoids, schizophrenics and the atypical manic-depressive cases because at present we have no better single form of treatment to offer them. (7) It is well for us to examine critically the results of our own labor, admit failure where it has occurred, and continue to strive for improved techniques and results. (8) The group that has failed to obtain permanent benefits from electroshock should, in selected cases, have insulin coma therapy or prefrontal lobotomy.

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Rehabilitation of the physically handicapped has become one of the most vital problems of the present time. The enormous acceleration of modern industry with its accidents is responsible for disabling of large numbers of workers. Each day traffic accidents, disease, congential deformity and recently the war add their toll.—E. M. Finesilver, M. D., Conn. State Med. Jour., Feb., 1950.

Case Report of Tetanus*

DOROTHY STANNARD ALLEN, M. D.

THIS is the case of a 58-year-old male who entered Mercy Hospital, Janesville, Wisconsin, in a wheelchair on September 20, 1947. His chief complaint was "stiffness of the right leg." Five days prior to his admission, the patient developed a sore throat and a swelling in the right gluteal region. At that time he had the sensation of muscles contracting in the neck, back, thighs, and legs. Two days prior to admission the patient noted increasing difficulty in opening his jaws and swallowing. In addition he felt pain in the posterior neck muscles. On the day of admission, there was soreness in the thoracic spinal muscles as well as in the posterior neck. He had had no fever and had lost his appetite. He was able to walk but rather haltingly because of stiffness in his right hip. Sitting or changing position was difficult.

His past medical history included the usual childhood diseases. He alleged addiction to morphine for the past 32 years and had used morphine in doses of six grains daily for a number of years. This is on record in the office of the Federal Narcotic Agent. The patient confessed that when he first began using the drug, he cleaned his hypodermic needles in alcohol, but through the years he became careless and dispensed with sanitary precaution.

The patient is married and before his illness came in contact daily in his work with soil. His family history was negative.

He was a stocky, debilitated male who appeared his stated age of 58 and was in acute distress. He was apprehensive and agitated. His speech was labored but he was able to swallow. Tissue turgor was poor. There were multiple hypodermic scars on the lateral surfaces of the right and left thighs and along the brachial veins of both arms. Some of the recent sites of injection showed pyogenic infection. Pupils were small and contracted and extra-ocular movements were normal. On retinal examination there was no edema of the discs. The jaws opened only slightly and the pharynx was not visualized. The neck was stiff on attempted active or passive flexion. The lungs were clear and heart tones were distant. The spine was hyperextended. The cremasteric reflex was positive. Superficial abdominal reflexes absent. Flexion and abduction of the right hip were limited with muscle spasm of the right thigh. The knee jerk on the right was three plus and on the left, two plus. The achilles jerk was unsatisfactory on both right and left. Ankle clonus was positive on the left and the Babinski was questionably positive on the right. The rest of the physical examination was negative.

The Author

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PROGRESS NOTES

Beginning on September 20, 1947, the progress notes show that at first the patient was isolated because he was suspected of having poliomyelitis. Morphine was administered—four doses of two grains each in the first twenty-four hours, together with ten grains of aspirin every three hours around the clock, and 40,000 units of penicillin every three hours.

Second day: the residence, Dr. Nuzum, made a tentative diagnosis of tetanus. The sensitivity tests for serum allergy were negative and 61,500 units of antitoxin serum was given intramuscularly.

Third day: Jaws became rigid and the patient was unable to talk and could swallow water with the greatest difficulty. Treatment: Tetanus antitoxin 20,000 units every four hours. Amigen 1,000 cc. intravenously followed by 1,000 cc. of five per cent glucose in saline. Paraldehyde 6 cc. intramuscularly. Aspirin stopped.

Fourth day: Jaws are set and thighs stiff. Involuntary urination and defecation. Respiration is irregular and of Cheyne Stokes variety. Tongue blade and pharyngeal airway inserted and suction used to keep it clear. Back arched three times and several convulsions lasted 20 minutes each. Treatment same. By far, the worst day.

Fifth day: Four generalized convulsions during the day. Muscle spasms fewer and less severe. Able to open jaws and neck less rigid. Penicillin stopped. Antitoxin ordered.

Sixth day: Delirious at times. Swallowing still impossible. Tetanus alum-precipitated toxoid 1 cc. intradermally ordered.* Antitoxin reduced to 10,000 units daily.

Seventh day: Definitely improved; coughing, wheezing and expectorating clear mucus. Sodium Amytal grains three by mouth as the nurse sees fit. Toxoid repeated.

Clinical Progress after September 27, 1947: Definite uphill progress. Patient went on a soft diet of cereals, bananas, etc. Sedations continued. Occasional purposeless movements of the legs, and, a few generalized convulsions until October 8, after which, there were no more convulsions or spasms. He slept for increasingly longer periods. Adrenalin and calamine lotion were given for a urticaria which developed on the hip and buttocks on October 2. Tetanus antitoxin stopped September 28. The patient displays increasing irrationality—he often states that he

* This case report is published both because of the lesson it teaches and in the belief that we should stimulate clinical contributions from interns, residents, and the younger practitioners.

* The purpose of this was to stimulate active immunity, but the question might well be raised, in the face of the fairly large and frequent doses of antitoxin, was not this toxoid also being neutralized by the antitoxin?

isn't sick and claims that the hospital is holding him—he insists on going to Beloit, Wisconsin. He worries frequently and expresses morbid fear of being left alone in his room. He was allowed up in a chair and was given bathroom privileges. After a hospital stay of 49 days he was discharged November 8, 1947, in an improved ambulatory condition. The final diagnosis by the attending physician, Dr. O. V. Overton, was tetanus and morphine addiction. The patient was discharged on a daily dosage of morphine of 6 grains. This is the same amount which he had been alloted by the Federal Narcotic agent before the admission of the patient to the hospital.

Totaling of Units of Antitoxin Used:

Sept. 21—	61,500	U.
Sept. 22—	100,000	U.
Sept. 23—	100,000	U.
Sept. 24—	60,000	U.
Sept. 25—	20,000	U.
Sept. 26—	30,000	U.
Sept. 27—	10,000	U.
	381,500	U.

COMMENTS

This case is of marked interest because of the patient's complicating morphinism added to the rare appearance of tetanus.* It was impossible in this instance to determine the incubation period since the addict exhibited multiple scars and abscesses due to repeated infections. These scars were distributed over anterior skin surfaces to which the patient had access for the narcotic was self-injected. According to his own admission, and in keeping with an addict's fundamental personality defect, he soon became lax in observance of sterile hypodermic technic. This, together with his daylong work in the fertilized soil of a greenhouse and nursery, afforded an ideal milieu for the contraction of tetanus. But it cannot be proved whether tetanus spores contaminated his needle and skin or whether spores were dusted into the many neglected and secondarily infected skin abscesses around the needle punctures.

But one thing is certain, the patient was not seen by a doctor until five days after the onset of the first symptoms which were: A sensation of muscles contracting in the neck, back, thighs, and legs; a deep, painful swelling in the right gluteal region, and a sore throat. Two days before he sought medical aid, he developed difficulty in opening his jaws and in swallowing, pain in the posterior neck and thoracic spinal muscles and stiffness of the right hip joint.

A working diagnosis was reached fairly promptly within sixteen hours after the patient's admission to the hospital. Since the patient was brought into the hospital during the waning of the season of poliomyelitis, the consideration of that disease was in the foreground for the first sixteen hours before the working diagnosis of tetanus was assumed. That explains the attempted but unsuccessful spinal tap and also the enforced isolation of the patient which was salubrious in view of the final diagnosis of tetanus.

The general condition of the patient when he came to the hospital was poor. He was weak, dehydrated, apprehensive, and could not walk for any distance because of acute muscle pain which persisted also at rest. On his third hospital day he developed generalized convulsions which did not disappear entirely until his seventeenth hospital day. Acute respiratory embarrassment did not appear until the fourth day in the hospital. The patient had an elevated fever which remained at 100 degrees or above for nineteen days and ranged from 98 to 103 degrees F. The highest recorded leucocytosis of 14,350 occurred on September 29, 1947.*

No attempt at isolation of the tetanus bacillus was made. Since there were probably upward of forty scars and infected needle punctures, it would have been an uncertain task of sampling pus from the wound or wounds which gave rise to bacilli. Fildes pointed out that for successful isolation, tissue of the wound should be excised and placed in a tube of meat infusion. He considered material taken on swabs or pipets to be unsatisfactory.

The early management, the writer believes to have been sufficient, insofar as 61,500 units of tetanus antitoxin were given intramuscularly on the second hospital day. Sedatives and ample intravenous fluids were prescribed, oral nourishment being encouraged throughout. The complication of morphine addiction had to be handled early. He received 6 grains of morphine daily, the same amount that he had consumed before his illness. In addition to morphine he received the following sedatives to reduce his response to stimuli; paraldehyde, sodium amytal, aspirin, and phenobarbital.

It is believed that the completeness of the patient's recovery testifies in this particular case to the adequacy of the treatment. Fairly heroic doses of antitoxin were given totaling 381,500 units over a period of seven days. Although he ran a stormy course, there were no complications of tetanus nor residual paralysis.

The discharge of the patient raised the question of sending him to a hospital specialized in the care of narcotic addicts for withdrawal therapy. However, evaluation of the patient's age, his confirmed addiction, and lack of inclination to be treated rated him as a poor risk for a successful cure without relapse; therefore, he was dismissed to his home.

* A review of the journal literature compiled by the Index Medicus from the years 1908 through and including 1946 disclosed only one listing of a case report of tetanus in a morphine addict per se, and that article was in a German journal of psychiatry (1930). Swerbejew, N. T..: Tetanus in a Morphine Addict, Case. Archives für Psychiatrie. 90:590-594, 1930.

* While several urinalyses and blood counts along with blood Wassermann were taken, all were negative and, therefore, not relevant to the discussion.

The Clinical Use of the Thematic Apperception Test

J. M. WITTENBROOK, M. D., R. T. SIDWELL, M. A., A. J. KANDIK, M. A.

IN the diagnosis and treatment of emotional disorders and other mental disturbances a great variety of tests are used. The most important of these are the various personality tests. Personality tests consist of two main types, the atomistic and the global. The atomistic test attempts to evaluate single properties of personality while the global test gives a more general picture of the personality and is for that reason a much more useful test. The global test is the more useful test because it allows greater projection by the individual. By this is meant that the social-stimulus situation is sufficiently ambiguous to allow the person to interpret the material in light of his own psychological structure. We know that simple perception is not the result of purely physiological functioning of brain and eye, but perception is actually "conditioned" by the emotional make-up, needs, and drives of the individual. A recent publication by Jerome Bruner and Cecile C. Goodman[4] at Harvard University gives in the bibliography some 36 references to other work on perception which nicely demonstrates that the perceiving subject's response to an object-stimulus is conditioned by the conflicts, motives, attitudes and strivings of the individual.

Probably the best known "projective technique" is the Rorschach Test. In this test ten cards with both chromatic and achromatic ink blots are presented to the patient and he is asked to give his impression of each card. With this test we are more concerned with discovering the structural or formal aspects of personality. The Thematic Apperception Test is a convenient adjunct to the Rorschach in that it is structured to exhibit what might be called the "content analysis" of personality; the particular strivings, attitudes, and motives of the person which have been developed in the course of individual experience. The Thematic Apperception Test is analogous to a picture of personality while the Rorschach is analogous to an X-ray of the personality.

THE TEST

The Thematic Apperception Test requires the patient to develop a story around the picture visually presented to him. The task is delineated to one form of response-verbal communication of a story about the picture which is recordable. This necessary structurization of the situation makes comparison of interpersonal relationships easier and also is supportive to the patient in that the presence of the picture facilitates his efforts at production. The aim of this test then is to confront the individual with a number of stimulus situations analogous to situations which may occur in everyday life, and thereby determine his mode of approach to these situations. His mode of approach, of course, is determined by his personality make-up and his vicarious identification with figures in the cards and what happens to them give valuable indices of his own dynamics.

We see, then, that the test is based on the well-recognized psychologic principle that a person will interpret an ambiguous social situation in light of his own personality make-up, thereby exposing his personality indirectly in analyzing the phenomenon to which he is attending. In his attempt to explain what seems an objective occurrence he becomes naively less conscious of himself and of the scrutiny of the examiner and thereby less defensively vigilant. To an examiner psychologically or psychiatrically oriented interpretation of the double meanings of what he is saying, discloses many inner fears, tendencies, wishes, and strivings of the patient. This is often referred to as the dynamic content of the story. By this we mean the human situations and human motives the patient has expressed which were prompted by the stories.

The revised form of the Thematic Apperception Test (TAT) which is now commonly used, is composed of 29 pictures and one blank card.

Presented before the Section on Nervous and Mental Diseases at the Annual Meeting of the Ohio State Medical Association, Columbus, April 21, 1949.

The Authors

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There is one series of ten cards common to both sexes and two series of ten cards used with either male or female patients. The clinician trained in the use of projective techniques quickly finds, however, that no sharp delineation by sex is necessary and will probably devise a battery of ten or more cards which he finds most efficacious to the type of patient he most commonly treats. As we have already noted the test enables the patient to either identify with or make general identifications of the figures presented and thereby reveal his ideational contents and attitudes relevant to that area of ideation. Thus we see there are pictures commonly referring to aggression, danger, fear, sexuality, suicide, and parent-child relationships. With the adolescent and child, omission is usually made of those pictures, for example, that have a more obvious sexual connotation. The number of stories to be obtained may be shortened if one is satisfied that the number of stories already obtained is conclusive, but the practice of shortening or limiting the series may be dangerous in that unsuspected conflicts may not be elicited and an oversimplification of the dynamics of the case may result. It is, therefore, inadvisable to use only those cards on which the examiner expects—on the basis of previous knowledge about the patient—to obtain decisive ideational content because, first, the most conclusive material may be given on cards least suspected to reveal this material, and secondly, the configuration and form of the narratives elicited on the various cards may give us a baseline by which to evaluate unusually brief, elaborate, or other disproportionate stories.

INSTRUCTIONS

There is no formal or stylized instruction for the test. The important point is that the patient understand what is expected of him, and, therefore, the instruction becomes only as elaborate as necessary for understanding on the part of the patient. A sample of an instruction given might be as follows: "I am going to show you a series of pictures and I want you to make up a story around each one. I want you to tell me what the situation is in the picture, what the events were that led up to it, and what the outcome will be. Describe the thoughts and feelings of the characters. I want a plot not an elaborate story. I shall write what you say as you go along." For the blank card additional instruction is necessary, and one might say this: "For this card, I want you to imagine a picture, describe it to me, and then tell me a story about it as you have done for the other cards." Good rapport with the patient is desirable, but good stories may be obtained as long as the patient is not showing active distaste or negativism toward the test situation. Actually, the test is used in many instances as a means of establishing better rapport with the patient and the time consumed in establishment of rapport is reduced. This particular point will be elaborated on later in the paper.

ADMINISTRATION

The test may be administered in one or two sessions. It is usually not advisable to give more than ten or twelve cards in one session as there is a certain fatigue element which enters in at this point. Many methods of recording the TAT protocols have been devised, some quite elaborate, but the two methods which seem most profitable are manual recording by the examiner or some type of tape or wire recording machine. Most clinicians do not have the physical arrangement of office space or the availability of stenographic help whereby a stenographer may sit behind a screen and take down the stories given as recommended by Murray. The obvious limitations of longhand recording by the examiner are that the patient must be slowed down in presentation of the story (which gives him greater intellectual control than in a more spontaneous situation), and it makes it most difficult to observe the patient during administration as the examiner is too busy getting the material down. Machine recording seems to be better as the testing can be more spontaneous and on playback voice inflection and obvious pauses and blockings can be detected. Again, there is a disadvantage to this recording method in that the material must be transcribed for evaluation, and a verbatim record may not be necessary and may be too time-consuming. Further, actual "mike fright" is sometimes encountered when the means of recording is made too obvious. One should devise some means, however, despite the method of recording used, to take additional behavior notes. This is most revealing at times when correlated with known case history material and story content presented.

All stories are timed and a total time and a reaction time are obtained for each story. This is helpful from the standpoint of giving valuable leads as the amount of "shock" or delay encountered by emotion-arousing pictures and their particular significance for that individual.

The test is composed of the actual administration of the picture cards and recording of protocols and an inquiry. There are two ways in which the inquiry of the stories elicited may be made. The examiner can make an inquiry while the patient is telling the story or right after he has finished telling it to learn more of the dynamics of the story. Secondly, the inquiry can be saved until all the protocols are obtained and then return to those stories about which

he desires more information. It is also valuable in the final inquiry to ask the source of each of the patient's stories, whether he got them from life, books, or movies.

The role of the examiner while the patient tells the story is essentially neutral. The examiner must indicate to the patient that he is interested in everything said, but must not show or express his own feelings over the material elicited from the patient.

INTERPRETATION

Because the problem of interpretation of the TAT has not been satisfactorily solved, one finds a diversity of methods of interpretation utilized. These methods differ with various clinicians according to their own requirements and experience. Classically, interpretation has been divided into formal and content analysis of the protocols obtained. Most clinicians devise some method which is an incorporation or combination of these two approaches. Probably, the most widely publicized method is that developed by Murray and Morgan, the test creators, and their co-workers at Harvard University. Their content analysis determines the major themes of each story and from these they ascertain the important needs, presses and attitudes of the patient. Morgan and Murray define the theme as the dynamic structure or plot of the story. These themes usually demonstrate the psychological pressures affecting the patient and indicate the needs which are the directional tensions in the patient's behavior. Sanford used the exhaustive analysis approach, which avoids seeking major themes of each story and concentrates on the sentence by sentence and phrase by phrase analysis of the needs and presses. The most common method, however, of content analysis utilizes the major theme without employing a strict objective method and listing of needs and presses. Commonly, we study the characters with whom the patient identifies and the many and various situations built around these characters from which the examiner infers the strivings of the patient and his attitudes and areas of conflict. The formal analysis usually consists of an analysis of the patient's approach to the test situation, the amount of "shock" or blocking produced by various cards (as indicated by reaction and total story time), the structurization, style, predominate mood, and the adequacy of his perception.

ADVANTAGES AND DISADVANTAGES

The advantages and the disadvantages of the test are many, but the writers feel that the following are probably the more important in light of having worked with the test over a period of time. The TAT itself does not give any material that could not be obtained by other methods but does obtain it in a more efficient manner. The fact that the material may be obtained by other means such as several months of treatment interviews, permits us to check the accuracy of the test. The greatest advantage of the test is that it gives important information about the personality of the patient in one or at the most two interviews. The time saved by this method, therefore, permits the clinician to do therapy more effectively and more economically. There is the further advantage that the test indicates not only the nature of the conflict but also the probable origin of it. The greatest disadvantage of the test is that it is a verbal test. Children who do not express themselves well in language or adults who tend to be uncommunicative do not produce stories which are suitable for interpretation. A further disadvantage is that the test requires that interpretation be made by an experienced or sophisticated clinician, otherwise the inexperienced clinician might possibly project his own subjective feelings into the interpretation.

USE IN DIAGNOSIS

With adults we are able to make a dynamic diagnosis based on knowledge of his psychopathology rather than a purely descriptive one. It also affords us an opportunity to obtain mental content from those who have reason to conceal their thinking. Two examples of such a use may be seen in the intelligent paranoid and the adult delinquent. Further, it can be likened to a laboratory procedure which can be used to check a clinical opinion.

It has been found, however, that the greatest use of the test has been in child psychiatry. This is to be expected since the child seldom comes for a diagnostic evaluation of his own volition. He is often frightened and is afraid that what he may say may be held against him and be the cause of punishment. This is especially true of the delinquent child who is obviously aware that the evaluation of his condition will determine what will be done with him. Many children, not delinquents, are fearful of adults and will refuse to answer ordinary questions but will enter into a situation showing some characteristic of a game. It is nearly always necessary to have the type of information this test gives in making recommendations for treatment. It is obvious in the delinquent child that one must learn as much as possible about the child in a very short time and to be able to use the information in determining where the child will be placed and what type of treatment he should have. Where we are dealing with the emotionally disturbed child we have a somewhat different situation. It is necessary to decide the seriousness of his disturbance and the need for further observation and care. In many instances

the child's emotional upset is comparatively mild and is secondary to that of the parents. In such a case the parents would be reassured to relieve their anxiety or the treatment would be concentrated on them. If the child shows a considerable amount of disturbance, the test results can be used to plan the length and depth of the treatment. In the more severe cases the results may indicate a need for resident therapy away from the home.

USE IN THERAPY

The Thematic Apperception Test can be a means of establishing rapport. It provides the patient with a formal means of entering into conversation with the therapist in the early stages of his treatment when he still feels some reluctance to discuss his problem. The test is a more desirable method of establishing rapport than casual conversation because it simultaneously obtains material directly relating to the patient's problem.

As a therapeutic procedure the test is useful in uncovering unconscious material. A patient is neurotic in part because of the emotionally traumatic situations he has experienced. Many of these situations have been apparently forgotten but have in reality been repressed into the unconscious mind. In the unconscious mind they remain active influencing the patient's feeling, thinking and perception. If through the use of this test we can bring these repressed memories from the unconscious to the conscious mind, the patient can then deal with them in an adequate and realistic manner so that his behavior becomes appropriate to the situation and ceases to be neurotic.

In spite of the fact that the patient may present himself for treatment, travel some distance for treatment, and personally meet the cost of the treatment, we cannot assume that there is a willingness to be treated. The patient may wish for a relief from the discomfort of his neurosis but still be unwilling to change. It is desirable to be able to assess this attitude in advance and be prepared to meet it. Card 12 which shows a young man on a couch with another man leaning over him is particularly useful for this purpose.

The test also provides a simple means of mental catharsis for the patient who is reluctant to discuss his conscious thoughts because of embarrassment or concern over the therapist's possible attitude to his thoughts once they are revealed. These thoughts can be presented in an "as if" or third person form which simultaneously permits ventilation of the problem and a testing of the therapist's attitudes by the patient. Once the patient feels safe in revealing his hidden thoughts to the therapist he can then abandon pretext and present remaining material in a more open fashion. The authors have seen material revealed by the test which in other patients with other forms of therapy required a year to obtain.

There are various therapeutic situations in which for various reasons prolonged or deep therapy is not desirable. Often this results from time limitation placed on therapy by the patient himself. By using information obtained from the TAT we can determine the patient's more urgent problems. These can at times be improved by employing suggestion, explanation and reassurance. These methods, of course, have their limitations but may afford sufficient relief to justify their use. The test is of further use in this type of therapy by giving us a clear indication of the seriousness of the problem so that we may know if we are justified in using a shortened therapy.

SUMMARY

This paper dealt with a projective technique known as the Thematic Apperception Test. This test presents a series of pictures to the examinee who then is asked to tell a brief story about each picture. It is most useful in bringing to light what might be called the content of personality, the particular conflicts, strivings, and attitudes which have been developed in the course of individual experience. The test is based upon the well-recognized principle that when a person interprets an ambiguous social situation he is apt to expose his own personality as much as the phenomenon to which he is attending.

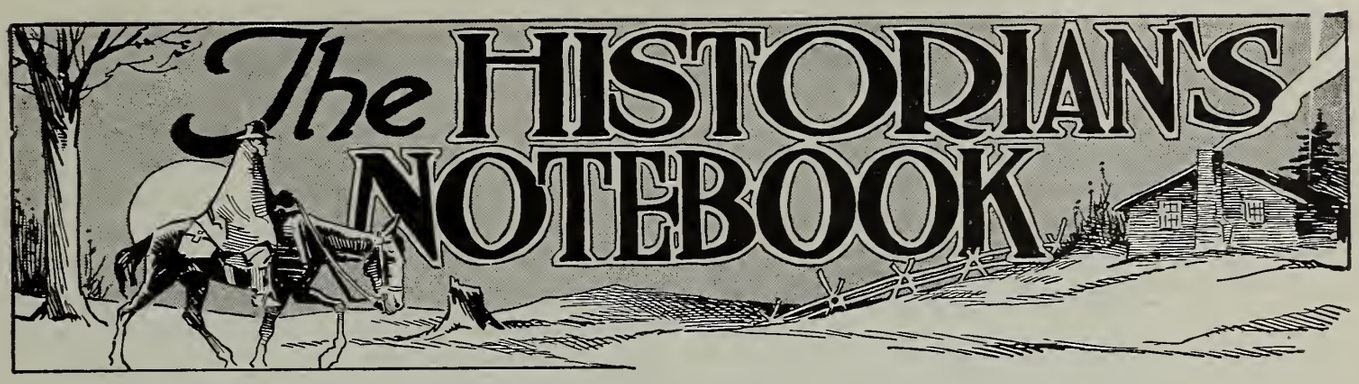
The TAT has been found useful in any comprehensive study of personality, and in the diagnosis of behavior disorders, psychosomatic illnesses, neuroses and psychoses. The technique is especially recommended as a preface to a series of psychotherapeutic interviews or to a short psychoanalysis.

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Dihydrogenated Alkaloids of Ergot

The dihydrogenated ergot alkaloids appear to act by adrenergic blockade resulting in a reduction of sympathetic tone with relaxation of the vessel wall. Regardless of the mode of action, an enlarged peripheral arterial and capillary bed was demonstrated in many of the patients showing favorable clinical response. The peripheral vessels in a normal individual are in a constant state of vasoconstriction necessary for the maintenance of body temperature.—Popkin, Calif. Medicine, Feb., 1950.



James E. Bauman's Service to the State of Ohio

ROBERT G. PATERSON, Ph.D.

PART II

(Concluded from March Issue)

WHEN I first met Jim it was a "time of trouble," to use Arnold Toynbee's phrase, for Dr. Probst, Jim and the State Board of Health. While the temptation is urgent to become caustic about this "time of trouble" I believe it best to use the temperate and kindly language of Dr. Probst who wrote about it some twenty-five years after it occurred. He says:

> "I must not say *too* much as to *why* I left, but some explanation is due my friends who may see this. From the creation of the State Board of Health, in 1886, to the time of my resignation in 1911, politics had never been considered except, perhaps, in the selection of some of its members. After their appointment it was never mentioned. I was given a free hand in the selection of its growing personnel but I always asked the Board's approval before heads of departments and their chief assistants were appointed. I made the appointments as the Board agreed that I would have better control of the employees if they knew they owed their position to me. This was all changed in 1911. An executive committee of two was appointed in that year. Without warning, nine positions were vacated, including the head of the laboratory. (The head of the Engineering Department resigned in disgust.) These vacancies were filled by the executive committee.
>
> "My removal was sought by this committee by asking an opinion of the Attorney-General as to whether I was an officer or an employee of the State. The Constitution of the State provided that an officer of the State must serve for a definite term. I had been appointed to serve during my good behavior and to be dismissed for cause only, and after a hearing. The Attorney-General, Mr. Timothy Hogan, a good friend, who knew the ins and outs of all this, declared that I was an employee; and further, that political affiliations (I was a Republican, the administration was Democratic) would not be considered a cause for removal.
>
> "At a meeting of the Board on August 10, 1911, at Toledo, unexpected by any member of the Board, except my dear old friend Mr. Hartzel, I handed in my resignation to be effective on the first of the following October. On that date my wife and I left for Vienna where, after a month in Davos, the greatest tuberculosis center in the world, I spent four months in postgraduate work."

The Greeks had a word for describing such a situation but unfortunately I cannot use it here!

At the time Dr. Probst resigned, his salary was $3,000 per annum; the annual appropriation was $45,182; and the personnel had increased to twenty-four, about equally divided between technical and clerical employees.

NAMED ACTING SECRETARY

Caught unaware, the State Board of Health appointed Jim as acting secretary and began looking around for a successor to Dr. Probst. This maneuver was to be repeated five additional times in Jim's long career. Jim served in this capacity for a period of nine months. Then Dr. E. F. McCampbell was appointed secretary on January 17, 1912, but did not begin his service until June 1, 1912. At the January meeting Jim was appointed assistant secretary.

Dr. McCampbell came from Marysville, had studied and taught bacteriology at The Ohio State University and received both his Bachelor of Science (1906) and Ph. D. (1910) at the University of Chicago and his M. D. degree from Rush Medical College in 1912. He was thirty-two years of age when he came to the State Board of Health. Dr. McCampbell was dynamic, realistic and had little reverence for the traditions that had been developing during Dr. Probst's regime.

Again Jim had a "time of trouble" in ad-

justing himself to the constant changes that were put into effect by Dr. McCampbell. It was a time of expansion and the pace was quite rapid. Bill Groeniger came in as State Inspector of plumbing on February 19, 1911; Frank G. Boudreau was appointed epidemiologist on July 1, 1911; and Bill Dittoe was appointed chief engineer December 1, 1911.

DIVISIONS NEEDED

By 1912, the staff had expanded to such a size that a more definite organization into divisions was desirable. Accordingly there were set up divisions of administration of which Jim was the chief; engineering, hygiene, laboratories, communicable diseases and plumbing inspection. This year also saw the convening of the fourth Ohio Constitutional Convention that kept the people of the State in a constant ferment over the debates that went on concerning the 340 proposals made during the period from January 9 to June 7, 1912.

James M. Cox, of Dayton, was elected Governor of Ohio in 1912 and took office in January, 1913. The Ohio Society for the Prevention of Tuberculosis had worked out a program in 1912 that called for an appropriation by the General Assembly of $25,000 a year for the establishment of a Division of Tuberculosis in the State Board of Health.

When the proposal was put before him, Governor Cox, who was a man of decisive character, agreed in less than ten minutes to urge the General Assembly to make the necessary appropriation. From March 23 to 27, 1913, occurred the great flood in Ohio and large emergency appropriations by the state had to be made to meet the disaster. In spite of this Governor Cox only reduced the amount for tuberculosis work from $25,000 to $20,000 per annum for the biennium, which passed the General Assembly.

On May 1, 1913, the Executive Secretary of the Ohio Society for the Prevention of Tuberculosis was loaned to the State Board of Health to organize the newly created Division of Tuberculosis. On May 15, 1913, Emery R. Hayhurst was brought into the Board to head the newly created Division of Industrial Hygiene and on October 1, 1915, Dr. Francis M. Hollingshead was appointed chief of the Division of Hygiene.

Growth in personnel and program continued until Dr. McCampbell resigned May 1, 1916, to become Dean of the Medical College of the Ohio State University. Again Jim was made acting secretary and on February 22, 1917, he became secretary of the Board. In the interim James M. Cox was elected Governor for the second time and a law was passed with his wholehearted approval abolishing the Ohio State Board of Health and transferring its powers and duties to a State Department of Health consisting of a Public Health Council of four members and a Commissioner of Health. The four members of the Council were appointed by the Governor for staggered terms, the first of whom was Dr. Charles O. Probst who served until his death. Thus were the old ties between Jim and Dr. Probst restored. The Commissioner of Health was appointed by the Council for a term of five years. After the passage of this act Jim was appointed to act as temporary secretary until a Commissioner of Health could be appointed.

PERIOD III. 1917-1921

Dr. Allen W. Freeman, of Cincinnati, was appointed Commissioner of Health August 28, 1917, and assumed office October 1, 1917. On that date Dr. Freeman appointed Jim as Deputy Commissioner. Dr. Freeman was thirty-six years of age and held an M. D. from Johns Hopkins University and practically all his professional life had been spent in public health work. At the time of his appointment he was epidemiologist with the United States Public Health Service stationed at Cincinnati.

Dr. Freeman has written about some of his experiences, among others, as Commissioner of Health of Ohio in his book entitled "Five Million Patients—The Professional Life of a Health Officer" published in 1946. This is what he has to say about the organization when he took charge:

"The organization which the Commissioner found in operation was far better than he had hoped. The last secretary of the old board had evidently been a good judge of men and had made his appointments without political interference. He had been out of office a full year when the new law took effect on July 1, 1917, and since his resignation the work of the department had been carried on by Mr. Bauman who served as acting secretary.

"Mr. Bauman was unique. He had come into the department many years before as a junior clerk and had later taken a degree in law and qualified for the bar without interrupting his work in the department. Through the thirty years of his service he had come to be the stabilizing personality of the organization, who had carried on during all the changes that had taken place. His knowledge of the state and its government was amazing.

"The technical staff of the department included an unusual proportion of men of ability, though some of the best were already in military service and others were preparing to follow them. The subordinate staff had been appointed under Civil Service procedures and was also of a quality above the average.

"The department's program was good. The State had been a pioneer in the control of water supplies and the prevention of stream pollution, and the engineering division was probably the best in the country.

The rest of the organization was fully abreast of the time and in some things well in advance."

HUGHES-GRISWOLD ACT

While it was recognized that the weak link in the health organization of Ohio was in the local areas and several attempts were made to provide corrective legislation, nothing happened until the devastating epidemic of influenza swept through the United States in 1918-19. The township and village health organization in Ohio collapsed completely. Governor Cox was still the dominant figure in the State and was quick to sense the need for a reorganization of the local health machinery. The present Hughes-Griswold Act of 1919-20 was passed. It abolished all township and village boards of health and created two main types of organization—(1) General health districts comprising all the territory in a county outside of municipalities; and (2) city health districts comprising populations of 5,000 or more. As a result of this legislation the number of local health authorities was reduced from 2,150 to 88 general and 80 city health districts, each with a board of health and each required to employ a health commissioner.

In January, 1921, the bureau of local health organization was established in the division of communicable diseases and in 1925 it was transferred to the division of administration of which Jim was chief. At long last Ohio was on its way toward meeting a fundamental problem that had been troubling the State Board of Health since 1886.

I believe I am right in saying that with the advent of Dr. Freeman, Jim entered into a period of four years of happy service, comparable with those he enjoyed under Dr. Probst. It was a welcome relief after the six years of stress and strain through which he had gone. He and Allen Freeman worked together as a good team.

PERIOD IV. 1921-1949

In 1921, Harry L. Davis of Cleveland was elected Governor of Ohio, and one of his platform pledges was a reorganization of the State Government. The bill to accomplish this became known as the Administrative Code and was patterned after the Federal plan of organization to provide departments, with the heads of departments constituting the Governor's Cabinet.

The main changes in the organization of the State Department of Health were: (1) The official title was changed to "Department of Health"; (2) the Commissioner of Health was replaced by a Director of Health to be appointed by the Governor and to serve at his pleasure; (3) the authority to create divisions was given to the Director, subject to the approval of the Governor; (4) the Director of Health was designated as chairman of the Public Health Council; (5) The Bureau of Vital Statistics was transferred to the Department of Health from the Secretary of State's office and was designated the "division of vital statistics."

Everyone interested in public health in Ohio protested against the change, insisting that the health department was not and should not be in politics and that the bill would inevitably make the director of health a political official.

FREEMAN RESIGNS

Dr. Freeman, being a Virginia Democrat and sensing that Republican Governor Davis had absolute control of the government, decided to accept an offer from Johns Hopkins to become Resident Lecturer in Public Health Administration in the School of Hygiene and Public Health. He resigned June 10, 1921, effective June 30, 1921. Then in quick succession as Director of Health were:

Dr. Harry H. Snively, appointed in 1921.
Dr. John E. Monger, appointed in 1923.
Dr. Charles A. Neal, appointed in 1929.
Dr. H. G. Southard, appointed in 1931.
Dr. Walter H. Hartung, appointed in 1935.
Dr. Roll H. Markwith, appointed in 1939.
James E. Bauman, acting Director of Health, 1944-5.
Dr. Roger Heering, appointed in 1945.
James E. Bauman, acting Director of Health, June 1, 1947, to August 1, 1947.
Dr. John D. Porterfield, appointed August 1, 1947.

No relaxation of the protests against this situation was permitted throughout the terms of the various Governors—Donahey, Cooper, White, and Davey—but to no avail.

In 1935, Martin L. Davey, of Kent, a Democrat, became Governor of Ohio. He appointed Dr. Walter H. Hartung, of Toledo, as Director of Health and it was not long before Governor Davey began his pressure to oust Jim from the Department. Jim was listed as a Republican. Dr. Hartung knowing how valuable Jim was to the work, resisted this pressure until it became a question who should go—Jim or Dr. Hartung. At this point Jim resigned and secured a position in the Engineering Department of Franklin County.

RESTORED TO POSITION

In 1939 John W. Bricker of Columbus, a Republican, was elected Governor and he was thoroughly informed about the situation, having served as Counsel to the Ohio Public Health Association since 1929. He appointed Dr. Roll H. Markwith, of Akron, as Director of Health but insisted that Jim should be restored to his former position in the Department. This was done in March, 1939. In May of 1939 with the cordial support and backing of Governor Bricker, an act was passed by the General Assembly whereby the Public Health Council was increased from four to six members and the Director of Health was to be

appointed by the Governor for a term of five years from a list of six names submitted to the Governor by the Public Health Council.

Upon the re-election of Governor Bricker in 1944, he appointed Dr. Roger E. Heering as Director of Health. Like Freeman before him, Dr. Heering was a member of the United States Public Health Service staff and well versed in publice health administration. When Dr. Heering resigned in 1947 to enter the private practice of medicine in Columbus, Governor Herbert appointed another trained United States Public Health Service man as Director of Health—Dr. John D. Porterfield.

RETIREMENT

Jim retired on June 30, 1949, after 57 years of service to the people of Ohio. Happily he is still among us in good health and spirits after all the buffeting he has weathered in the Department. As one reads the record one is conscious of the fact that the early history of the public health movement in Ohio is well recorded. In 1915 the General Assembly decreed that departmental reports were no longer to be published by each department. After that date the State published a volume called "Ohio General Statistics" which was thought to furnish all the information the public required and thus the State of Ohio could save money. But this venture never met the needs of those who were interested in the details of a particular department. In 1929 Dr. C. A. Neal, with the approval of Governor Cooper, had prepared a volume that covered the period from 1915 to 1929. Since 1929 we have no published reports so that there is an hiatus in the record of twenty years. It appears vital to some of us interested in the historical aspects of the public health movement in Ohio that this gap be filled up as soon as possible. We would urge Dr. Porterfield and the Public Health Council to lay plans for such an undertaking and to make use of Jim's amazing knowledge of the work.

I close this brief and inadequate recounting of Jim's life work with a thought from Shakespeare's Othello:

"I have done the state some service and they know't."

Gallia County History

After reading the "History of Medicine in Gallia County" in the February issue of *The Journal*, a member wrote: "No history of the county is complete without the mention of Captain John N. Carnes, U. S. Army, killed in service while based at Hawaii in 1943. John, a graduate of Ohio State, 1940, was one of the best loved young men in the community and, to my knowledge, the only Gallia County physician who lost his life in service."

Dr. James Craven Wood 1859-1948

At the time of the division of the Cleveland Homeopathetic College in 1890, the new "Cleveland Medical College" could not find anyone to fill the professorship of Gynecology still held by Dr. Biggar in the old college. After a nation-wide search for the right man, Dr. J. C. Wood who taught the subject for eight years at the University of Michigan was chosen. He came to Cleveland in 1894 where he rounded out thirty-two years of teaching in medical colleges. It was natural that these two leaders should be rivals—and they were. Each was outstanding among scores of other homeopathic leaders in Cleveland in the last century who were equally great and who also served, but these men were especially prominent and beloved by their students and patients.

Dr. Wood found in Dr. Biggar a strong antagonist and rival. But the Huron Road group grew tired of the fray and accepted Dr. Biggar's resignation after four or five years, upon which the two colleges reunited under the name of the Cleveland Homeopathic Medical College, which graduated its first class in 1898.

Dr. Wood was born of fine family stock near Bowling Green, Ohio, in 1859. His father was General Henry L. Wood, a prosperous farmer of Wood County and his son had the industrious outlook of a farm boy. He graduated at Ohio Wesleyan University, taught country school, went to business college, and graduated in the homeopathic department of the University of Michigan at Ann Arbor.

Dr. Wood was a man of notable qualities; great refinement and culture with a splendid education and an attractive personality. He was a man of rare judgment, a writer of note, a nationally known and highly regarded surgeon and gynecologist and a tower of strength to the Cleveland homeopathic hospital and college. When Dr. Biggar resigned, the two colleges united, and Dr. Wood was in sole charge of gynecology in the College and in Huron Road Hospital.

Among his many achievements in the medical world were presidency of the American Institute of Homeopathy in 1902, fellowship in the American Association, founding membership in the American College of Surgeons and membership on its board of governors for twenty years, membership in the International Congress of Gynecology and Obstetrics and presidency of the Belgian session in 1892, and past presidency of the Michigan and the Ohio Homeopathic Medical Societies.

After a brilliant career in medicine and surgery spanning sixty-nine years, he passed away in August, 1948, at the age of ninety with his mind unimpaired.—Lucy S. Hertzog, M. D., Chardon, Ohio.



ANNOUNCING

Official Program

for the

1950 ANNUAL MEETING

OHIO STATE MEDICAL ASSOCIATION

CLEVELAND

May 16, 17, and 18, 1950

ON this and the following pages will be found detailed information on the program and schedule of events for the 1950 Annual Meeting of the Ohio State Medical Association. This year's is a streamlined calendar, concentrated to give doctors the best in postgraduate sessions within conservative time limits.

TIME AND PLACE: Tuesday, Wednesday and Thursday, May 16, 17 and 18, 1950. Note that the new streamlined time schedule calls for the scientific program to begin at 1 p. m., Tuesday, and end at 3:45 p. m. on Thursday. Scientific programs and exhibits will be in the Cleveland Public Auditorium, only a short walk from downtown hotels. The House of Delegates will meet in the Hotel Cleveland—the first session Tuesday beginning at 10 a. m. Specialty groups will meet as announced in the following pages.



REGISTRATION: Registration Headquarters will be in the Main Entrance Lobby of the Cleveland Public Auditorium—open from 8 a. m. to 6 p. m. on Tuesday and Wednesday and from 8 a. m. to 4 p. m. on Thursday. There is no registration charge. Admission to all sessions will be by badge secured at Registration Headquarters. Those eligible to register are: Members of the Ohio State Medical Association (who should have 1950 Membership Cards for presentation at time of registration); physicians from other states who are members of their respective state medical societies; residents, interns, medical students, nurses, health workers, and others who are presented at Registration Headquarters by members. The Woman's

Auxiliary will provide registration facilities for its members and others eligible for membership.

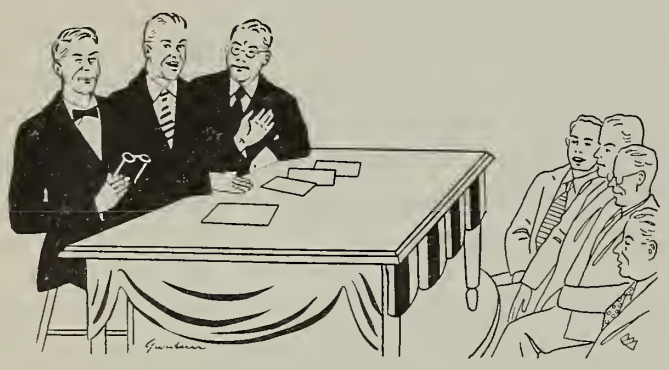
SCIENTIFIC SESSIONS: All scientific, clinical and instructional sessions scheduled by the Ohio State Medical Association will be held in the Cleveland Public Auditorium. For the General Sessions, scientific programs are being sponsored by the Specialty Sections to the interest of physicians in all branches of medicine. See detailed program in the following pages for exact place and time. Some specialty societies will hold sessions as listed in the detailed program.



HOUSE OF DELEGATES: Two sessions of the House of Delegates will be held, both in the Hotel Cleveland. The first session will be on Tuesday, May 16, beginning at 10 a. m. and followed by luncheon. The second session is scheduled for Thursday, May 18, beginning with a luncheon at 12 noon.

MEDICAL TOPICS OF THE DAY: Six of these panel discussion sessions will be held—three on Tuesday and three on Wednesday, from 1 to 2:30 p. m. Doctors will have a choice of attending any one of the three sessions on two successive days. These programs are conducted on a slightly more formal basis than the Instructional Courses, but get away from the scientific paper presentation procedure. See Tuesday and Wednesday schedules for details.

INSTRUCTIONAL COURSES: Fourteen of these informal discussion sessions have been scheduled. They are especially designed to provide members with practical instruction on handling of clinical problems arising in everyday practice—especially in the general practice of medicine. Procedure follows the line of panel discussions, with questions from the audience playing a large part in the formal presentations.



A review of the detailed program in the following pages will convince members that outstanding clinicians in their respective fields have been selected as moderators and discussants.

Attendance to the Instructional Courses will be by tickets only. Experience during previous meetings has shown that these courses are very popular, while seating capacity necessarily is limited. Those who plan to attend, therefore, should apply for tickets in advance of the meeting.

A special folder on the Instructional Courses and other Annual Meeting events will be mailed to each member in the near future. This folder should be read carefully because it will give information on how to secure Instructional Course tickets. There is no charge for the tickets; the procedure is for the purpose of making reservations only.



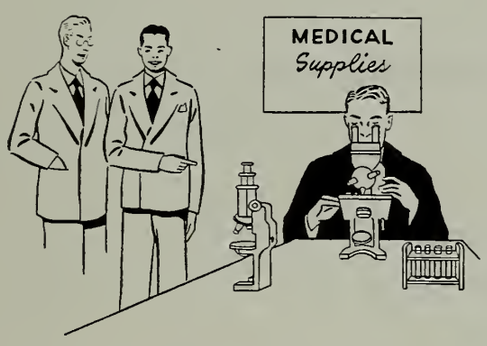
The discussions will be held during three separate periods so that a doctor may schedule three complete Instructional Courses. The first of the series will be held from 9 to 10:30 a. m. on Wednesday, May 17. The second series will be from 9 to 10:30 a.m. on Thursday, May 18, and the third series from 10:30 a. m. to 12 noon on Thursday.

See Wednesday and Thursday programs on the following pages for topics, discussants and other details.

SPECIALTY SOCIETIES: Several societies of medical specialists have announced programs during the Annual Meeting of the Ohio State Medical Association. These include: Ohio Academy of General Practice, annual meeting, Tuesday, May 16, 7:30 p. m., Hotel Cleveland; Cleveland Society of Neurology and Psychiatry, social hour for members of Section on Nervous and Mental Diseases of the Ohio State Medical Association, Tuesday, May 16, 5 p. m., Hollenden Hotel; Ohio State Radiological Society, annual meeting, Wednesday, May 17, 9 a. m., Statler Hotel; and the Ohio Chapter, American College of Chest Physicians, annual meeting, noon luncheon, Wednesday, May 17, Hotel Statler. See following pages for details.

NATIONAL AFFAIRS: Two outstanding guest speakers are scheduled to appear on the program for the purpose of discussing national affairs. The Honorable Robert A. Taft of Ohio, member of the U. S. Senate, will talk on pending legislative proposals and vital national problems. Dr. George F. Lull, Chicago, secretary and general manager of the American Medical Association, will discuss the National Educational Program and other activities of the A. M. A. They will speak at a general session on Wednesday morning, May 17.

SCIENTIFIC EXHIBITS: These educational features will emphasize the latest developments in medical research and investigation. Displayed studies will offer members an opportunity to discuss results with persons directly responsible for their development. Recess periods throughout the session will give members ample time to browse through these exhibits and study those in which they may be specially interested. The exhibits will be in the Main Floor Arena of the Public Auditorium.



TECHNICAL EXHIBITS: These commercial displays offer opportunity for doctors to view the latest developments in pharmaceutical products, surgical instruments, therapeutic equipment and the like with respective promoters. Technical as well as scientific exhibits will be in the Main Arena. Ample time will be provided between sessions for inspecting this feature. Physicians always find that commercial projects add considerable to the educational material displayed at the Annual Meeting.

AUXILIARY: The Woman's Auxiliary of the Ohio State Medical Association will hold its annual meeting concurrently with the Annual Meeting of the Association. Auxiliary meetings will be held in the Hotel Cleveland. Detailed program will be found elsewhere in this issue.



ANNUAL BANQUET: This main social function of the Annual Meeting will be held on Wednesday evening, May 17, on the Mezzanine Floor of the Hotel Cleveland. The banquet will be followed by an evening of entertainment and dancing. No formal program. Because this primarily is a social function, a nominal fee of $5.50 each will be charged those who wish to attend. To insure reservations, tickets should be ordered in advance of the meeting. Instructions for making reservations will be contained in the special folder which will be mailed to each member.

TUESDAY, MAY 16

TIME		
10:00 A. M. to 12:00 Noon	HOUSE OF DELEGATES BUSINESS SESSION AND	
	MEDICAL TOPICS OF THE DAY	
1:00 P. M. to 2:30 P. M.	**RISK FACTORS IN ANESTHESIA** Room B—North Wing Third Floor **R. J. WHITACRE, M. D.** **East Cleveland, Moderator** *(See following pages for details)*	**NEPHRITIS AND NEPHROSIS** Room A—South Wing Second Floor **J. M. HAYMAN, JR., M. D.** **Cleveland, Moderator** *(See following pages for details)*
2:30 P. M. to 3:00 P. M.	RECESS FOR VISITING THE EXHIBITS	
3:00 P. M. to 3:45 P. M.	PSYCHIATRY IN GENERAL PRACTICE MAURICE LEVINE, M. D. Cincinnati	
3:55 P. M. to 4:25 P. M.	PRESENT-DAY PRACTICE IN OBSTETRIC ANALGESIA GEORGE J. ANDROS, M. D. Ann Arbor, Mich.	
4:25 P. M. to 4:55 P. M.	MODERN CONCEPTS OF ANESTHETIC MANAGEMENT FOR GYNECOLOGICAL AND OBSTETRICAL PATIENTS RALPH M. TOVELL, M. D. Hartford, Conn.	
4:55 P. M. to 5:25 P. M.	RESUSCITATION OF THE NEWBORN J. J. JACOBY, M. D. Columbus	

MEETING—1950

CLEVELAND PUBLIC AUDITORIUM

TUESDAY, MAY 16

LUNCHEON, BALLROOM, MEZZANINE FLOOR, HOTEL CLEVELAND

MEDICAL TOPICS OF THE DAY

NEUROSES AND EARLY PSYCHOSES IN GENERAL PRACTICE

Ballroom — North Wing — Fourth Floor

CALVIN L. BAKER, M. D.
Columbus, Moderator

(See following pages for details)

RECESS FOR VISITING THE EXHIBITS

GENERAL SESSION

BALLROOM, NORTH WING, FOURTH FLOOR

1950—ANNUAL

OHIO STATE MEDICAL ASSOCIATION

WEDNESDAY, MAY 17

TIME	Instructional Course 1 Ballroom—North Wing Fourth Floor	Instructional Course 2 Room C—South Wing Fourth Floor
9:00 A. M. to 10:30 A. M.	**TREATMENT OF HEART DISEASE** A. CARLTON ERNSTENE, M. D. Cleveland, Moderator *(See following pages for details)*	**OFFICE ANESTHESIA** K. C. McCARTHY, M. D. Toledo, Moderator *(See following pages for details)*
9:00 A. M. to 12:00 Noon	**ANNUAL MEETING OF THE OHIO STATE RADIOLOGICAL SOCIETY,**	
10:30 A. M. to 12:00 Noon	**THE HONORABLE ROBERT A. TAFT, of Ohio, Member of the United States Senate** and **GEORGE F. LULL, M. D., Chicago, Ill., Secretary and General Manager of the American Medical Association**	
	MEDICAL TOPICS OF THE DAY	
1:00 P. M. to 2:30 P. M.	**CONVULSIVE DISORDERS: RECOGNITION AND TREATMENT** Room A — South Wing — Second Floor MAX T. SCHNITKER, M. D. Toledo, Moderator *(See following pages for details)*	
2:30 P. M. to 3:00 P. M.	**RECESS FOR VISITING THE EXHIBITS**	
3:00 P. M. to 3:15 P.M.	DIABETIC KETOSIS CECIL STRIKER, M. D Cincinnati	
3:15 P.M. to 3:30 P. M.	URINARY BLADDER EMERGENCIES EUGENE A. OCKULY, M. D. Toledo	
3:30 P. M. to 3:45 P. M.	IMMEDIATE MANAGEMENT OF HEAD INJURIES JOSEPH P. EVANS, M. D. Cincinnati	
3:55 P. M. to 4:40 P. M.	FULL SCALE X-RAY CHEST EXAMINATIONS FRED J. HODGES, M. D. Ann Arbor, Mich.	
4:45 P. M. to 5:30 P. M.	METABOLIC EFFECTS IN MAN OF ACTH AND CORTISONE (COMPOUND E) JEROME W. CONN, M. D Ann Arbor, Mich.	
7:30 P. M.	**ANNUAL BANQUET, BALLROOM,**	

MEETING—1950

CLEVELAND PUBLIC AUDITORIUM

WEDNESDAY, MAY 17

Instructional Course 3	Instructional Course 4	Instructional Course 5
Room B—South Wing Third Floor	Room A—South Wing Second Floor	Room B—North Wing Third Floor
BLOOD TRANSFUSIONS	**DRUG THERAPY IN THE AGED**	**DIAGNOSIS AND TREATMENT OF THE INFERTILE COUPLE**
HORACE B. DAVIDSON, M. D. Columbus, Moderator *(See following pages for details)*	JOSEPH I. GOODMAN, M. D. Cleveland, Moderator *(See following pages for details)*	ALLAN C. BARNES, M. D. Columbus, Moderator *(See following pages for details)*

EUCLID ROOM, STATLER HOTEL, FOLLOWED BY LUNCHEON IN PINE ROOM

GENERAL SESSION

BALLROOM, NORTH WING, FOURTH FLOOR

MEDICAL TOPICS OF THE DAY

PERIPHERAL VASCULAR DISORDERS Room B—South Wing Third Floor	**RETROPERITONEAL TUMORS** Room C—South Wing Fourth Floor
WILLIAM D. HOLDEN, M. D. Cleveland, Moderator *(See following pages for details)*	WILLIAM J. ENGEL, M. D. Cleveland, Moderator *(See following pages for details)*

RECESS FOR VISITING THE EXHIBITS

GENERAL SESSION

BALLROOM, NORTH WING, FOURTH FLOOR

MEZZANINE FLOOR, HOTEL CLEVELAND

THURSDAY, MAY 18

TIME	Instructional Course 6 Room B—South Wing Third Floor	Instructional Course 7 Ballroom—North Wing Fourth Floor
9:00 A. M. to 10:30 A. M.	**OSTEOPOROSIS AND OTHER DISEASES OF BONE** CHARLES A. DOAN, M. D. Columbus *(See following pages for details)*	**POLIOMYELITIS** JAMES G. KRAMER, M. D. Akron *(See following pages for details)*
10:30 A. M. to 12:00 Noon	**Instructional Course 11** Room B—South Wing Third Floor **PEDIATRIC ROENTGENOLOGIC DIAGNOSIS** FREDERIC N. SILVERMAN, M.D. Cincinnati *(See following pages for details)*	**Instructional Course 12** Room A—South Wing Second Floor **INJURIES TO THE CHEST, ABDOMEN AND SPINE** DONALD M. GLOVER, M. D. Cleveland *(See following pages for details)*
12:00 Noon	**LUNCHEON AND BUSINESS SESSION OF HOUSE OF**	
1:30 P. M. to 1:50 P. M.	PREVENTION AND TREATMENT OF DEAFNESS IN CHILDREN HARRY C. ROSENBERGER, M. D. Cleveland	
1:50 P. M. to 2:10 P. M.	EARLY RECOGNITION OF VISUAL DEFECTS IN CHILDREN LORAND V. JOHNSON, M. D. Cleveland	
2:15 P. M. to 3:00 P. M.	THE PRIMARY TUBERCULOUS COMPLEX: SOME CLINICAL AND ROENTGENOGRAPHIC FEATURES JOHN CAFFEY, M. D. New York	
3:00 P. M. to 3:45 P. M.	REVIEW OF ACUTE UPPER RESPIRATORY DISEASES JOHN H. DINGLE, M. D. Cleveland	

MEETING—1950

CLEVELAND PUBLIC AUDITORIUM

THURSDAY, MAY 18

Instructional Course 8
Room A—South Wing
Second Floor

PROLONGED LABOR

RICHARD D. BRYANT, M. D.
Cincinnati

(See following pages for details)

Instructional Course 9
Room C—South Wing
Fourth Floor

CARE OF THE NEWBORN AND PREMATURE

CHARLES F. McKHANN, M. D.
Cleveland

(See following pages for details)

Instructional Course 10
Room B—North Wing
Third Floor

ANTIBIOTICS

MAURICE A. SCHNITKER, M. D.
Toledo

(See following pages for details)

Instructional Course 13
Ballroom—North Wing
Fourth Floor

UNDERSTANDING AND TREATING THE ALCOHOLIC

CHARLES W. HARDING, M. D.
Columbus

(See following pages for details)

Instructional Course 14
Room C—South Wing
Fourth Floor

EMERGENCIES IN EYE, EAR, NOSE AND THROAT

CLAUDE S. PERRY, M. D.
Columbus

(See following pages for details)

DELEGATES, BALLROOM, MEZZANINE FLOOR, HOTEL CLEVELAND

GENERAL SESSION

BALLROOM, NORTH WING, FOURTH FLOOR

TUESDAY, MAY 16

10:00 A. M.—12:00 Noon

HOUSE OF DELEGATES

FIRST BUSINESS SESSION AND LUNCHEON FOR MEMBERS OF THE HOUSE OF DELEGATES

Ballroom, Mezzanine Floor, Hotel Cleveland

TUESDAY, MAY 16

1:00 to 2:30 P. M.

Cleveland Public Auditorium

MEDICAL TOPICS OF THE DAY

RISK FACTORS IN ANESTHESIA

Room B, North Wing, Third Floor

Moderator: R. J. Whitacre, M. D., East Cleveland, Director, Department of Anesthesiology, Huron Road Hospital, East Cleveland.

Panel Discussants:

The Anesthetist: Skill, Experience and Equipment—Ralph M. Tovell, M. D., Hartford, Conn.

Medical Conditions Influencing Anesthesia—D. E. Hale, M. D., Cleveland.

Emergencies of Anesthesia—A. J. Fisher, M. D., Youngstown.

NEPHRITIS AND NEPHROSIS

Room A, South Wing, Second Floor

Moderator: J. M. Hayman, Jr., M. D., Cleveland, Professor of Medicine, Western Reserve University School of Medicine.

Panel Discussants: Max Miller, M. D., Arthur C. Corcoran, M. D., Cleveland; Frederick S. Coombs, M. D., Youngstown; Albert A. Brust, M. D., Cincinnati; George I. Nelson, M. D., Columbus.

NEUROSES AND EARLY PSYCHOSES IN GENERAL PRACTICE

Ballroom, North Wing, Fourth Floor

Moderator: Calvin L. Baker, M. D., Columbus, Commissioner of Mental Hygiene, Ohio Department of Public Welfare.

Panel Discussants: Clyde B. Simson, M. D., Dayton; Thomas E. Rardin, M. D., Columbus; Howard D. Fabing, M. D., Cincinnati; A. V. Black, M. D., Centerville.

2:30 to 3:00

RECESS FOR VISITING THE EXHIBITS



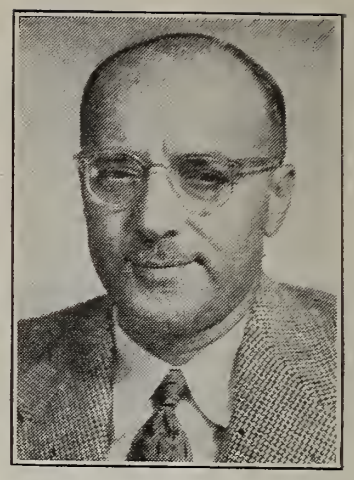
R. J. WHITACRE, M. D.



J. M. HAYMAN, JR. M.,D.



C. L. BAKER, M. D.



MAURICE LEVINE, M.D.

TUESDAY, MAY 16

3:00 P. M.

GENERAL SESSION

Ballroom, North Wing, Fourth Floor
Public Auditorium

3:00 to 3:45

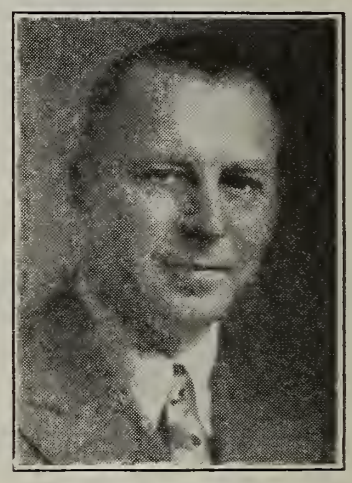
The following address is sponsored by the Section on Nervous and Mental Diseases.

PSYCHIATRY IN GENERAL PRACTICE

Maurice Levine, M. D., Cincinnati, Professor of Psychiatry, University of Cincinnati College of Medicine.



G. J. ANDROS, M. D.



R. M. TOVELL, M. D.

3:45 to 3:55

RECESS

3:55 P. M.

The following three addresses are jointly sponsored by the Section on Obstetrics and Gynecology and the Section on Anesthesiology.

3:55 to 4:25

PRESENT-DAY PRACTICE IN OBSTETRIC ANALGESIA

George J. Andros, M. D., Ann Arbor, Mich., Assistant Professor of Obstetrics and Gynecology, University of Michigan Medical School.

4:25 to 4:55

MODERN CONCEPTS OF ANESTHETIC MANAGEMENT FOR GYNECOLOGICAL AND OBSTETRICAL PATIENTS

Ralph M. Tovell, M. D., Hartford, Conn., Lecturer in Anesthesia, Yale University School of Medicine, New Haven.

4:55 to 5:25

RESUSCITATION OF THE NEWBORN

J. J. Jacoby, M. D., Columbus, Associate Professor of Surgery, Ohio State University College of Medicine.

WEDNESDAY, MAY 17

9:00 to 10:30 A. M.

Cleveland Public Auditorium

INSTRUCTIONAL COURSES

(Admission by Ticket Only)

1. TREATMENT OF HEART DISEASE

Ballroom, North Wing, Fourth Floor

Moderator: A. Carlton Ernstene, M. D., Cleveland, Chief of Staff, Division of Medicine, Cleveland Clinic.

Panel Discussants:

Congestive Heart Failure—John W. Martin, M. D., Cleveland.

Angina Pectoris—Johnson McGuire, M. D., Cincinnati.

Acute Myocardial Infarction—R. W. Scott, M. D., Cleveland.

Cardiac Arrhythmias—R. K. Bartholomew, M. D., Dayton.

Ohio Academy of General Practice To Hold Annual Meeting

The Annual Meeting of the Ohio Academy of General Practice will be held at the Hotel Cleveland, Tuesday, May 16, at 7:30 p. m. This will be a business meeting at which the nomination and election of state officers and state Board of Directors from the even numbered districts will take place; voting of new proposed amendments to the Constitution and By-Laws will be accomplished; report of all Committee Chairmen, and installation of the President-Elect and the newly elected officers. All members are urged and requested to be present.

2. OFFICE ANESTHESIA

Room C, South Wing, Fourth Floor

Moderator: K. C. McCarthy, M. D., Toledo, Director of Anesthesiology, Maumee Valley Hospital.

Panel Discussants: A. S. Gardiner, M. D., Cincinnati; D. H. Goodman, M. D., Cleveland; Leo Weiss, M. D., Toledo.

3. BLOOD TRANSFUSIONS

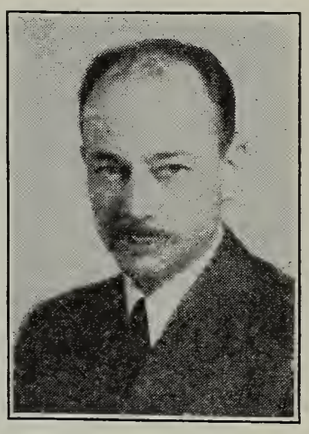
Room B, South Wing, Third Floor

Moderator: Horace B. Davidson, M. D., Columbus, Assistant Professor of Pathology, Ohio State University College of Medicine.

Panel Discussants: Paul Hoxworth, M. D., Cincinnati; Robert Daly, M. D., C. J. DeLor, M. D., John P. Garvin, M. D., Warren E. Wheeler, M. D., Columbus.



A. C. ERNSTENE, M. D.



K. C. McCARTHY, M. D.



H. B. DAVIDSON, M. D.



J. I. GOODMAN, M. D.

4. DRUG THERAPY IN THE AGED

Room A, South Wing, Second Floor

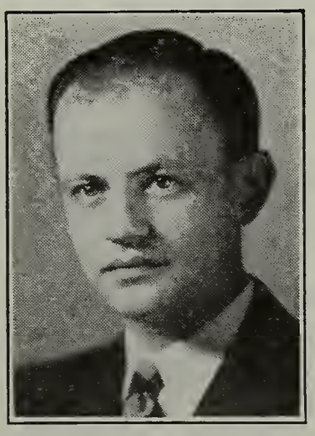
Moderator: Joseph I. Goodman, M. D., Cleveland, Senior Clinical Instructor, Western Reserve University School of Medicine.

Panel Discussants:

Central Nervous System — Siegfried Baumoel, M. D., Cleveland.

Cardiovascular Drugs—Harold Feil, M. D., Cleveland.

Hormone Therapy in the Aged—Reginald A. Shipley, M. D., Cleveland.



A. C. BARNES, M. D.

5. DIAGNOSIS AND TREATMENT OF THE INFERTILE COUPLE

Room B, North Wing, Third Floor

Moderator: Allan C. Barnes, M. D., Columbus, Chairman, Department of Obstetrics and Gynecology, Ohio State University College of Medicine.

Panel Discussants: George Wilcoxon, M. D., Alliance; Wm. F. Forsythe, M. D., Cleveland; Irving Rothchild, Ph. D., Columbus.

WEDNESDAY, MAY 17
9:00 A. M.

ANNUAL MEETING OF OHIO STATE RADIOLOGICAL SOCIETY

Euclid Room, Statler Hotel

Edward L. Voke, M. D., Akron ..... President
Arnold D. Piatt, M. D., Newark ..... Vice-President
Edward C. Elsey, M. D., Cincinnati ..... Secy.-Treas.

Members of Executive Committee:

Edward L. Voke, M. D., Akron
Arnold D. Piatt, M. D., Newark
Edward C. Elsey, M. D., Cincinnati
Donald D. Brannan, M. D., Cleveland
Huston F. Fulton, M. D., Columbus

9:00 to 10:00

RADIO-ACTIVE COBALT. INTERSTITIAL AND OTHER METHODS FOR THE USE OF COBALT 60 (SIXTY) IN CANCER THERAPY

Joseph L. Morton, M. D., Associate Professor of Radiology, Ohio State University College of Medicine, Columbus.

10:00 to 11:00

MASS SURVEY PROCEDURES IN RADIOLOGY

Fred J. Hodges, M. D., Professor of Radiology, University of Michigan Medical School, Ann Arbor, Mich.

11:00 to 12:00

RADIO-ACTIVE IODINE IN THE DIAGNOSIS AND TREATMENT OF HYPERTHYROIDISM

Hymer L. Friedell, M. D., Professor of Radiology, Western Reserve University School of Medicine, Cleveland.

Reginald A. Shipley, M. D., Department of Radiology.

John P. Storaasli, M. D., Department of Radiology.

12:00 Noon

Pine Room, Statler Hotel

Business Luncheon Meeting for Members of the Ohio State Radiological Society

WEDNESDAY, MAY 17
10:30 A. M. to 12:00 Noon

GENERAL SESSION

Ballroom, North Wing, Fourth Floor
Public Auditorium

Address: The Honorable Robert A. Taft of Ohio, Member of the United States Senate; subject—"Progress in Medical Care."

Address: George F. Lull, M. D., Chicago, Ill., Secretary and General Manager of the American Medical Association.

WEDNESDAY, MAY 17

ANNUAL MEETING OF OHIO CHAPTER AMERICAN COLLEGE OF CHEST PHYSICIAINS

Hotel Statler

Karl P. Klassen, M. D., Columbus, President
E. F. Conlogue, M. D., Dayton, Secretary-Treasurer



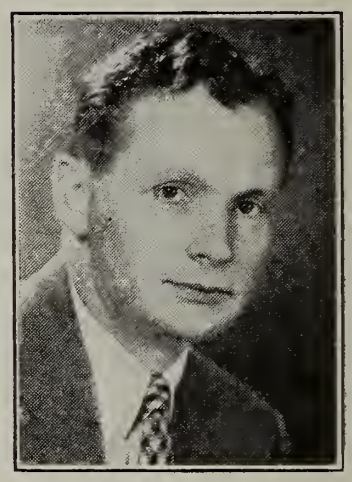
THE HON. R. A. TAFT



G. F. LULL, M. D.



M. T. SCHNITKER, M. D.



W. D. HOLDEN, M. D.

12:00 Noon

LUNCHEON

CORRELATED BRONCHOGRAMS IN TUBERCULOSIS

Maurice G. Buckles, M. D., Columbus.

WEDNESDAY, MAY 17
1:00 to 2:30 P. M.

MEDICAL TOPICS OF THE DAY

CONVULSIVE DISORDERS: RECOGNITION AND TREATMENT

Room A, South Wing, Second Floor

Moderator: Max T. Schnitker, M. D., Toledo, Chief, Department of Neurosurgery, St. Vincent's Hospital.

Panel Discussants: Howard Fabing, M. D., Cin-

Section on Nervous-Mental Diseases Invited for Social Hour

Members of the Section on Nervous and Mental Diseases of the Ohio State Medical Association attending the Annual Meeting are invited by the Cleveland Society of Neurology and Psychiatry to attend a cocktail party at 5 p. m., Tuesday, May 16, at the Hollenden Hotel, East Sixth Street and Superior Avenue.

cinnati; Joseph L. Fetterman, M. D., Cleveland.

PERIPHERAL VASCULAR DISORDERS

Room B, South Wing, Third Floor

Moderator: William D. Holden, M. D., Cleveland, Associate Professor of Surgery, Western Reserve University, School of Medicine.

Panel Discussants: Richard W. Zollinger, M. D., Columbus; Lawrence Peters, M. D., and Lawrence Atlas, M. D., Cleveland.

RETROPERITONEAL TUMORS

Room C, South Wing, Fourth Floor

Moderator: William J. Engel, M. D., Cleveland, Urologist, Cleveland Clinic.

Panel Discussants: Fred Douglass, M. D., Toledo; Parke G. Smith, M. D., Cincinnati; John B. Hazard, M. D., Cleveland; T. Leucutia, M. D., Detroit, Mich.

2:30 to 3:00

RECESS FOR VISITING THE EXHIBITS

WEDNESDAY, MAY 17

3:00 P. M.

GENERAL SESSION

Ballroom, North Wing, Fourth Floor
Public Auditorium

The following three addresses are sponsored by the Section on General Practice.

3:00 to 3:15

DIABETIC KETOSIS

Cecil Striker, M. D., Cincinnati, Senior Attending Physician, Jewish Hospital, Cincinnati.

3:15 to 3:30

URINARY BLADDER EMERGENCIES

Eugene A. Ockuly, M. D., Toledo, Department of Urology, St. Vincent's Hospital, Toledo.

3:30 to 3:45

IMMEDIATE MANAGEMENT OF HEAD INJURIES

Joseph P. Evans, M. D., Cincinnati, Associate Professor of Surgery, University of Cincinnati College of Medicine, and Director of the Division of Neurological Surgery.

3:45 to 3.55

RECESS

3:55 to 4:40

The following address is sponsored by the Ohio State Radiological Society.

FULL SCALE X-RAY CHEST EXAMINATIONS

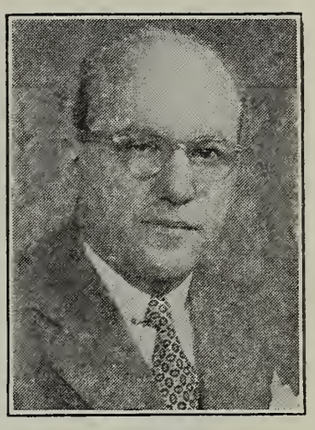
Fred J. Hodges, M. D., Ann Arbor, Mich., Professor of Roentgenology and Chairman, Department of Roentgenology, University of Michigan Medical School.

4:40 to 4:45

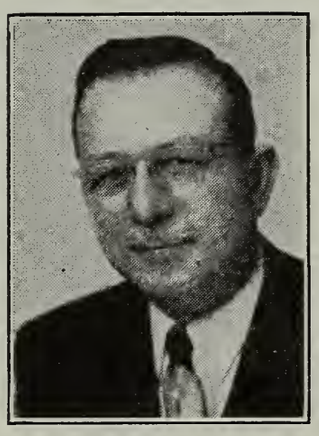
RECESS



W. J. ENGEL, M. D.



CECIL STRIKER, M. D.



E. A. OCKULY, M. D.



J. P. EVANS, M. D.

4:45 to 5:30

The following address is sponsored by the Section on Medicine.

METABOLIC EFFECTS IN MAN OF ACTH AND CORTISONE (COMPOUND E)

Jerome W. Conn, M. D., Ann Arbor, Mich., Associate Professor of Internal Medicine, University of Michigan Medical School.

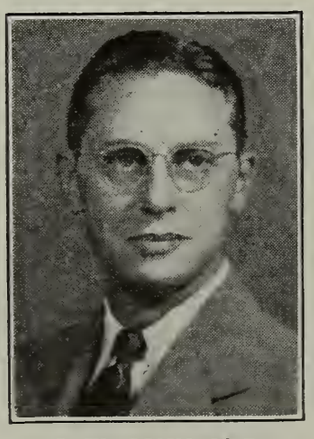
WEDNESDAY, MAY 17

7:30 P. M.

ANNUAL BANQUET

Ballroom, Mezzanine Floor, Hotel Cleveland

MUSIC DANCING
ENTERTAINMENT



J. W. CONN, M. D.



C. A. DOAN, M. D.

THURSDAY, MAY 18

9:00 to 10:30 A. M.

Cleveland Public Auditorium

INSTRUCTIONAL COURSES

(Admission by Ticket Only)

6. OSTEOPOROSIS AND OTHER DISEASES OF BONE

Room B, South Wing, Third Floor

Moderator: Charles A. Doan, M. D., Columbus, Dean, College of Medicine, Ohio State University.

Panel Discussants: Joseph L. Morton, M. D., Dept. of Radiology; George J. Hamwi, Dept. of Medicine, and Hans G. Schlumberger, Dept. of Pathology, all of Ohio State University, Columbus.

7. POLIOMYELITIS

Ballroom, North Wing, Fourth Floor

Moderator: James G. Kramer, M. D., Akron, Pediatrician to Akron Children's Hospital, Akron City Hospital, and Summit County Children's Home.

Panel Discussants: Alex J. Steigman, M. D., New York, N. Y.; Robert Eiben, M. D., Cleveland; Walter M. Solomon, M. D., Cleveland; and Albert L. Bershon, M. D., Toledo.

8. PROLONGED LABOR

Room A, South Wing, Second Floor

Moderator: Richard D. Bryant, M. D., Cincinnati, Assistant Professor, Department of Obstetrics, University of Cincinnati College of Medicine.

Panel Discussants: A. Hirsheimer, M. D., Dayton; N. E. Wentsler, M. D., Akron; Burdette Wylie, M. D., Lakewood; Dean Sheldon, M. D., Sandusky.

9. CARE OF THE NEWBORN AND PREMATURE

Room C, South Wing, Fourth Floor

Moderator: Charles F. McKhann, M. D., Cleveland, Professor of Pediatrics, Western Reserve University School of Medicine.

Panel Discussants:

Prematurity—J. Victor Greenebaum, M. D., Cincinnati.

Resuscitation of the Newborn—Marion M. Black, M. D., Cleveland.

Hemorrhage—Robert D. Mercer, M. D. Cleveland.

Infection—Samuel Spector, M. D., Cleveland.

10. ANTIBIOTICS

Room B, North Wing, Third Floor

Moderator: Maurice A. Schnitker, M. D., Toledo.

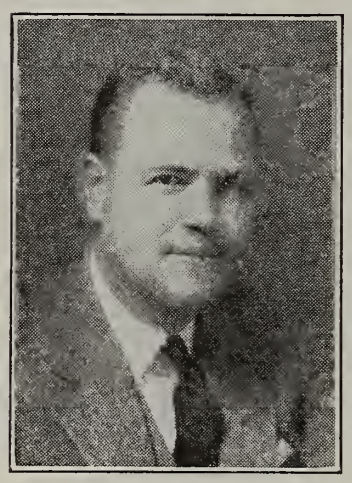
Panel Discussants: Charles H. Rammelkamp, M. D., Cleveland; Norman W. Thiessen, M. D., Lakewood; John E. Brown, Jr., M. D., Columbus.



J. G. KRAMER, M. D.



R. D. BRYANT, M. D.



C. F. McKHANN, M. D.



M. A. SCHNITKER, M. D.

10:30 A. M. to 12:00 Noon

11. PEDIATRIC ROENTGENOLOGIC DIAGNOSIS

Room B, South Wing, Third Floor

Moderator: Frederic N. Silverman, M. D., Cincinnati, Director, Department of Roentgenology, Children's Hospital.

Panel Discussants: Eugene L. Saenger, M. D., Cincinnati; James F. Martin, M. D., Cleveland; W. H. R. Howard, M. D., Columbus; John Caffey, New York, N. Y.

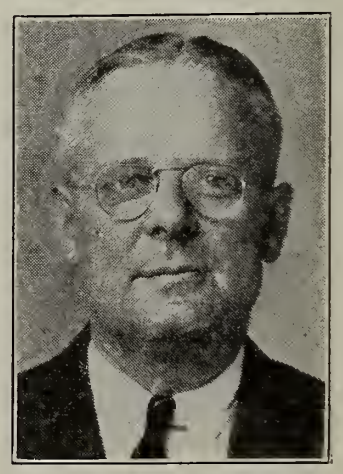
12. INJURIES TO THE CHEST, ABDOMEN AND SPINE

Room A, South Wing, Second Floor

Moderator: Donald M. Glover, M. D., Cleveland, Associate Clinical Professor of Surgery, Western Reserve University School of Medicine.



F. N. SILVERMAN, M. D.



D. M. GLOVER, M. D.

Panel Discussants: Edward Harlan Wilson, M. D., Columbus; William H. Falor, M. D., Akron; Vinton E. Siler, M. D., Cincinnati; Stanley O. Hoerr, M. D., Cleveland.

13. UNDERSTANDING AND TREATING THE ALCOHOLIC

Ballroom, North Wing, Fourth Floor

Moderator: Charles W. Harding, M. D., Columbus, Instructor, Neuropsychiatry Dept., Ohio State University and Clinical Consultant, University Hospital, Columbus.

Panel Discussants: Philip Piker, M. D., Cincinnati; Carl Wyler, M. D., Cincinnati; Edward O. Harper, M. D., Cleveland; D. W. Badal, M. D., Cleveland; and Charles L. Anderson, Harding Sanitarium, Worthington.

14. EMERGENCIES IN EYE, EAR, NOSE, AND THROAT

Room C, South Wing, Fourth Floor

Moderator: Claude S. Perry, M. D., Columbus.

Panel Discussants: Albert L. Brown, M. D., Cincinnati; Charles I. Thomas, M. D., Cleveland; William H. Evans, M. D., Youngstown; D. W. Brickley, Jr., M. D., Marion.

THURSDAY, MAY 18

12:00 Noon

HOUSE OF DELEGATES

LUNCHEON FOR MEMBERS OF THE HOUSE OF DELEGATES AND FINAL BUSINESS SESSION

Ballroom, Mezzanine Floor, Hotel Cleveland

THURSDAY, MAY 18

1:30 P. M.

GENERAL SESSION

Ballroom, North Wing, Fourth Floor
Public Auditorium

The following two addresses are sponsored by the Section on Eye, Ear, Nose and Throat.

1:30 to 1:50

PREVENTION AND TREATMENT OF DEAFNESS IN CHILDREN

Harry C. Rosenberger, M. D., Cleveland, Senior Visitant in Otolaryngology, St. Luke's Hospital, Cleveland.

1:50 to 2:10

EARLY RECOGNITION OF VISUAL DEFECTS IN CHILDREN

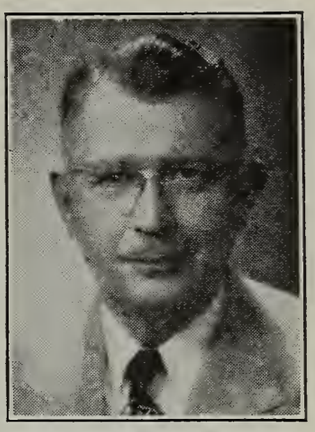
Lorand V. Johnson, M. D., Cleveland, Associate Professor of Ophthalmology, Western Reserve University School of Medicine.

2:10 to 2:15

RECESS



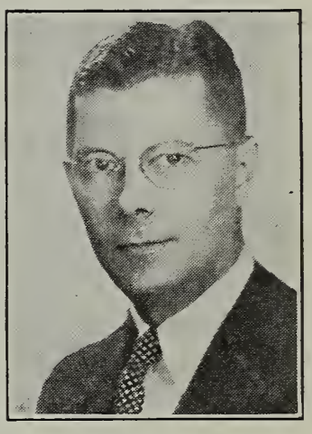
C. W. HARDING, M. D.



C. S. PERRY, M. D.



H. C. ROSENBERGER, M.D.



L. V. JOHNSON, M. D.

2:15 to 3:00

The following address is sponsored by the Section on Pediatrics.

THE PRIMARY TUBERCULOUS COMPLEX: SOME CLINICAL AND ROENTGENOGRAPHIC FEATURES

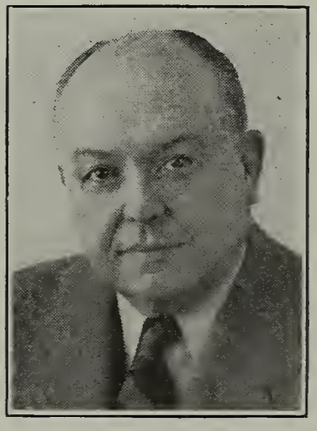
John Caffey, M. D., New York, N. Y., Professor of Clinical Pediatrics, College of Physicians and Surgeons, Columbia University.

3:00 to 3:45

The following address is sponsored by the Section on Public Health and Preventive Medicine.

REVIEW OF ACUTE UPPER RESPIRATORY DISEASES

John H. Dingle, M. D., Cleveland, Professor of Preventive Medicine and Associate Professor of Medicine, Western Reserve University School of Medicine.



JOHN CAFFEY, M. D.



J. H. DINGLE, M. D.

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for the

1950 Annual Meeting

Ohio State Medical Association

Cleveland, Ohio . . . May 16, 17, 18

NAME AND LOCATION	SINGLE	DOUBLE	DOUBLE TWIN BED
ALLERTON HOTEL, 1802 E. 13th St.	$3.50-6.50	$5.50-10.00	$6.00-10.00
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CLEVELAND HOTEL (Headquarters Hotel)	$4.50	$6.50-9.00	$9.00-14.00
HOLLENDEN HOTEL, 610 Superior Ave.	$3.50-8.00	$5.50-10.00	$7.00-14.00
OLMSTEAD HOTEL, Superior & E. Ninth	$3.00-6.00	$5.00-8.00 $7.00-9.50	$7.00-9.50
STATLER HOTEL, Euclid at E. 12th St.	$4.00-6.00	$7.00-10.00	$8.00-12.00

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Hotel, Cleveland, Ohio

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 16, 17, 18, 1950, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price ....

☐ Twin Bed Room with Bath ☐ Suite

Arriving May.....at.....A. M.....P. M.

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SCIENTIFIC AND EDUCATIONAL EXHIBITS

THE Scientific and Educational Exhibits in the Arena, Main Floor, Cleveland Public Auditorium, will be open daily from 9:00 A. M. to 6:00 P. M. on Tuesday, May 16, and Wednesday, May 17; and from 9:00 A. M. to 12:00 Noon on Thursday, May 18.

TRANSLUMBAR ARTERIOGRAPHY

Parke G. Smith, M. D., T. W. Rush, M. D., and Arthur T. Evans, M. D., Division of Urology, College of Medicine, University of Cincinnati.

TREATMENT OF COLLES' FRACTURES

Joseph M. Strong, M. D., Elyria Memorial Hospital and Gates Hospital for Crippled Children, Elyria.

PULMONARY RESECTION IN TUBERCULOSIS

Maurice G. Buckles, M. D., and Wm. L. Potts, M. D., Benjamin Franklin Hospital, Department of Thoracic Surgery, Ohio State University, Columbus.

AGNOSIA, APRAXIA, APHASIA

Robert E. Slemmer, M. D., College of Medicine, University of Cincinnati; Thomas Scott, M. D., Roy J. Secrest, M. D., Harry E. LeFever, M. D., Columbus; Department of Anatomy, St. Mary's Hospital, Cincinnati; College of Medicine, Ohio State University; Department of Neurosurgery, White Cross Hospital, Columbus.

FIRST TEN YEARS—CLEVELAND HEALTH MUSEUM

Bruno Gebhard, M. D., Director, Cleveland Health Museum, Cleveland.

HEBERDEN'S NODES—OSTEOARTHRITIS OF FINGER JOINTS

R. M. Stecher, M. D., Walter M. Solomon, M. D., Ralph Wolpaw, M. D., Cleveland City Hospital, Cleveland.

BONE TUMORS FOUND IN A SMALL HOSPITAL—FIVE-YEAR PERIOD

M. C. Kolczun, M. D., D. A. Russell, M. D., R. D. Berkebile, M. D., Charles Chesner, M. D., St. Joseph Hospital, Lorain.

TUMORS OF THE HEAD AND NECK

Clifford L. Kiehn, M. D., Donald M. Glover M. D., Plastic Surgery Section, Department of Surgery, School of Medicine, Western Reserve University, Cleveland.

NASAL SINUSES

Fred W. Dixon, M. D., Department of Otolaryngology, Western Reserve University, Cleveland.

CORONERS' PROBLEMS

S. R. Gerber, M. D., Cleveland, Ohio State Coroners' Association.

THE TREATMENT OF ANEMIA

Charles S. Higley, M. D., Willard C. Stoner, M. D., Richard G. Norby, M. D., St. Lukes Hospital, Cleveland.

FASCIA IN REPAIR OF HERNIAS

Robert C. Austin, M. D., and Eugene F. Damstra, Dayton.

SPINAL ANESTHESIA

J. J. Jacoby, M. D., Ohio Society of Anesthetists, University Hospital, Columbus.

THE SURGICAL MANAGEMENT OF INTRATHORACIC ABNORMALITIES OF THE NEWBORN

Karl P. Klassen, M. D., Douglas R. Morton, M. D., Department of Research Surgery, Ohio State University, Columbus.

TUMORS OF THE LUNG: PATHOLOGICAL ASPECTS AND BRONCHIAL SMEAR INTERPRETATION

John B. Hazard, M. D., Donald B. Effler, M. D., Department of Pathology, Cleveland Clinic Hospital, Cleveland.

PATHOGENESIS OF ERYTHROBLASTOSIS FETALIS

Viola Startzman, M. D., Roger Marster, Ph. D., Babies' and Children's Hospital, MacDonald House of University Hospitals, Cleveland. Benjamin Kline, Mount Sinai Hospital, Cleveland.

FLUOROSCOPIC SPOT-FILM TECHNIQUE IN CHOLECYSTOGRAPHY

Mortimer Lubert, M. D., George Krause, M. D., Department of Radiology, Mount Sinai Hospital, Cleveland.

BLOOD FACTOR IN ACUTE LUPUS ERYTHEMATOSUS

John R. Haserick, M. D., Cleveland Clinic Hospital, Cleveland.

PHYSICAL MEDICINE REHABILITATION

Bert A. Treister, M. D., U. S. Veterans Administration Hospital, Brecksville.

OCCUPATIONAL LUNG DISEASE

James P. Hughes, M. D., Kettering Laboratory of Applied Physiology, University of Cincinnati, College of Medicine, Cincinnati, and Carroll C. Dundon, M. D., Department of Radiology, University Hospitals of Cleveland.

PRECANCEROUS LESIONS AND CANCER OF THE SKIN AND MUCOUS MEMBRANES

Harold N. Cole, Sr., M. D., James R. Driver, M. D., Harold N. Cole, Jr., M. D., Department of Dermatology and Syphilology, Western Reserve University, School of Medicine, Cleveland.

STILL SPACE IN SCIENTIFIC EXHIBIT, IF YOU HURRY

There still is space available in the Scientific and Educational Exhibit at the 1950 Annual Meeting in Cleveland, May 16, 17 and 18.

Those having material suitable for this exhibit should get in touch with Dr. Charles L. Hudson, 2102 Abington Rd., Cleveland, chairman of the Committee on Scientific and Educational Exhibit.

TECHNICAL EXHIBITORS

ARENA, MAIN FLOOR, CLEVELAND PUBLIC AUDITORIUM

Open from 9:00 A. M. to 6:00 P. M. on Tuesday, May 16, and Wednesday, May 17; and from 9:00 A. M. to 12:00 Noon on Thursday, May 18

Exhibitor	Address	Booth Number
Abbott Laboratories,	North Chicago, Ill.	101
Aloe Company, A. S.,	St. Louis, Mo.	57
Ames Company, Inc.,	Elkhart, Ind.	16
Ayerst, McKenna & Harrison, Limited,	New York, N. Y.	41
Baby Development Clinic,	Chicago, Ill.	83
Baker Laboratories, Inc., The,	Cleveland, Ohio	29
Beech-Nut Packing Co.,	Canajoharie, N. Y.	20
Borden Company, The,	New York, N. Y.	3
Bowman Bros. Drug Co., The,	Canton, Ohio	76, 77
Burroughs Wellcome & Co. (U. S. A.) Inc.,	Tuckahoe, N. Y.	43
Caldwell and Bloor Company, The,	Mansfield, Ohio	90
Camel Cigarettes,	New York, N. Y.	98, 99
Cameron Surgical Specialty Company,	Chicago, Ill.	19
Camp & Company, S. H.,	Jackson, Mich.	52
Carnation Company,	Los Angeles, Cal.	61
Ciba Pharmaceutical Products, Inc.,	Summit, N. J.	60
Coca-Cola Company, The,	Atlanta, Ga.	87, 88
Columbus Hospital Supply Co.,	Columbus, Ohio	75
Denver Chemical Mfg. Co., Inc., The,	New York, N. Y.	50
Electro Medical Equipment Co.,	Cleveland, Ohio	74
Endo Products, Inc.,	Richmond Hill, N. Y.	36
Fischer & Co., H. G.,	Franklin Park, Ill.	65
Fleet Co., Inc., C. B.,	Lynchburg, Va.	58
Garinger X-Ray Sales,	Cleveland, Ohio	97
General Electric X-Ray Corporation,	Cleveland, Ohio	71
Gerber Products Company,	Fremont, Mich.	13
Heinz Company, H. J.,	Pittsburgh, Pa.	8
Holland-Rantos Company, Inc.,	New York, N. Y.	2
"Junket" Brand Foods,	Little Falls, N. Y.	7
Kelley-Koett Manufacturing Co., The,	Covington, Ky.	25, 26
Kremers-Urban Co.,	Milwaukee, Wis.	47
Lanteen Medical Laboratories, Inc.,	Evanston, Ill.	38
Lea & Febiger,	Philadelphia, Pa.	46
Lederle Laboratories Division, American Cyanamid Co.,	New York, N. Y.	73
Liebel-Flarsheim Company, The,	Cincinnati, Ohio	27, 28
Lilly and Company, Eli,	Indianapolis, Ind.	48
M & R Dietetic Laboratories, Inc.,	Columbus, Ohio	24
Massengill Company, S. E., The,	Bristol, Tenn.	64
Mead Johnson & Company,	Evansville, Ind.	33
Medical Aids, Inc.,	Chicago, Ill.	40
Medical Protective Company, The,	Fort Wayne, Ind.	42
Merrell Company, Wm. S., The,	Cincinnati, Ohio	59
Mosby Company, C. V., The,	St. Louis, Mo.	10
Mueller & Company, V.,	Chicago, Ill.	68
Natenberg, Maurice,	Chicago, Ill.	63
National Drug Co., The,	Philadelphia, Pa.	5
Ohio Medical Indemnity, Inc.,	Columbus, Ohio	89
Ortho Pharmaceutical Corporation,	Raritan, N. J.	55
Parke, Davis & Company,	Detroit, Mich.	67
Pelton & Crane Company, The,	Detroit, Mich.	70
Pet Milk Company,	St. Louis, Mo.	17, 18
Philip Morris & Co., Ltd., Inc.,	New York, N. Y.	54
Picker X-Ray Corporation,	New York, N. Y.	44, 45
Safety First Supply Company,	Pittsburgh, Pa.	39
Sanborn Company,	Cambridge, Mass.	14
Sandoz Chemical Works, Inc., Pharmaceutical Division,	New York, N. Y.	6
Saunders Company, W. B.,	Philadelphia, Pa.	49
Schenley Laboratories, Inc.,	New York, N. Y.	51
Schering Corporation,	Bloomfield, N. J.	72
Schuemann—Jones Co., The,	Cleveland, Ohio	102, 103
Searle & Co., G. D.,	Chicago, Ill.	37
Sharp & Dohme, Inc.,	Philadelphia, Pa.	53
Smith, Kline & French Laboratories,	Philadelphia, Pa.	31
Squibb & Sons, E. R.,	New York, N. Y.	9
Swift & Company,	Chicago, Ill.	32
Testagar & Co., Inc.,	Detroit, Mich.	4
U. S. Vitamin Corporation,	New York, N. Y.	11
Upjohn Company, The,	Kalamazoo, Mich.	30
Van Pelt & Brown, Inc.,	Richmond, Va.	62
Warren-Teed Products Company, The,	Columbus, Ohio	1
Wendt-Bristol Co., The,	Columbus, Ohio	15
Westinghouse Electric Corporation,	Pittsburgh, Pa.	21, 22
White-Haines Optical Company, The,	Columbus, Ohio	12
White Laboratories, Inc.,	Newark, N. J.	23
Winthrop-Stearns, Inc.,	New York, N. Y.	34
Wocher & Son Company, Max, The,	Cincinnati, Ohio	100
Wyeth, Incorporated,	Philadelphia, Pa.	56

DELEGATES AND ALTERNATES

Counties	Delegates	Alternates
FIRST DISTRICT		
ADAMS	S. J. Ellison	R. L. Lawwill
BROWN	W. L. Faul	Geo. P. Tyler, Jr.
BUTLER	Neil Millikin	J. F. Borelli
	C. T. Atkinson	William Neel
CLERMONT	J. M. Coleman	A. A. Gruber
CLINTON	E. K. Yantes	R. R. Buchanan
HAMILTON	Arthur W. Wendel	Robert H. Kotte
	Joseph Lindner	C. R. Rittershofer
	Richard D. Bryant	Richard B. Homan
	John W. Hauser	Daniel V. Jones
	William F. Hunting	Robert M. Woolford
	Kent E. Martin	Charles S. Blase
	Charles H. Moore	Herbert J. Brinker
	Herman J. Nimitz	J. S. McMath
	Stanley D. Simon	J. Edwin Reed
		Daniel C. Rivers
HIGHLAND	J. Martin Byers	Leland D. McBride
WARREN	O. L. Layman	A. E. Stout
SECOND DISTRICT		
CHAMPAIGN	D. C. Houser	E. R. Earle
CLARK	S. C. Yinger	Carl T. Doeing
	R. M. Turner	E. W. Schilke
DARKE	J. E. Gillette	Gilbert E. Sayle
GREENE	H. C. Messenger	Paul D. Espey
MIAMI	G. A. Woodhouse	Harry E. Shilling
MONTGOMERY	R. S. Binkley	
	A. W. Carley	
	R. D. Dooley	
	T. L. Light	
PREBLE	E. P. Trittschuh	C. W. Beane
SHELBY	H. E. Crimm	V. W. LeMaster
THIRD DISTRICT		
ALLEN	F. P. Berlin	R. L. Tecklenberg
AUGLAIZE	C. W. Berry	R. S. Oyer
CRAWFORD	John S. Kiess	J. W. Arnold
HANCOCK	Frank M. Wiseley	Harold Treece
HARDIN	Floyd M. Elliott	H. R. Johanson
LOGAN		Warren F. Mills
MARION	A. E. Morrison	Robert T. Gray
MERCER	L. M. Otis	Ralph J. Beare
SENECA	R. F. Machamer	Paul J. Leahy
VAN WERT	R. E. Shell	T. L. Edwards
WYANDOT		
FOURTH DISTRICT		
DEFIANCE	D. J. Slosser	Paul B. Newcomb
FULTON	E. R. Murbach	R. E. Merrill
HENRY	B. L. Johnson	Thomas W. Quinn
LUCAS	A. L. Bershon	H. L. Hauman
	O. E. Todd	T. C. Kiess
	E. E. Lyon	J. W. Erkert
	R. Kuebbeler	D. C. Frick
	R. A. Diethelm	C. R. Forrester
OTTAWA	G. A. Boon	C. R. Wood
PAULDING	R. H. Mouser	G. L. Doster
PUTNAM	W. B. Recker	M. B. Rice
SANDUSKY	J. J. Gedert	E. B. Vogel
WILLIAMS	H. R. Mayberry	R. A. Gilreath
WOOD	Paul F. Orr	R. N. Whitehead
FIFTH DISTRICT		
ASHTABULA	M. R. Martin	P. J. Collander
CUYAHOGA	H. B. Wright	E. A. Marshall
	D. A. Chambers	J. W. Conwell
	J. H. Budd	P. A. Mielcarek
	D. C. Darrah	I. L. Schonberg
	C. L. Hudson	W. E. Smith
	J. T. Ledman	Walter Zeiter
	J. E. Brown	E. F. Schroeder
	George A. Tischler	W. F. Boukalik
	F. L. Browning	F. A. Spittler
	L. H. Dembo	G. T. Kent
	C. S. Higley	G. L. Sackett
	W. P. Garver	J. D. Osmond, Jr.
	H. A. Crawford	R. J. Whitacre
	J. M. Rossen	
	I. M. Hinnant	
GEAUGA	Phillip P. Pease	Alton W. Behm
LAKE	Morris G. Carmody	B. S. Park
SIXTH DISTRICT		
COLUMBIANA		
MAHONING	V. L. Goodwin	R. E. Odom
	I. C. Smith	C. A. Gustafson
	Wm. M. Skipp	J. C. Vance
PORTAGE	Robert M. Dumm	R. C. Neely, Jr.
STARK	John E. Dougherty	A. A. Lichtblau
	C. C. Couch	G. M. Wilcoxon
	R. K. Ramsayer	Harry Beck
SUMMIT	Kurt Weidenthal	W. T. Bucher
	C. A. Raymond	J. W. Ewing
	E. W. Burgner	R. G. McCready
	F. T. Moore	R. H. Wilson
TRUMBULL	D. Thomas	S. J. Shapiro
SEVENTH DISTRICT		
BELMONT	Harvey H. Murphy	David Danenberg
CARROLL	W. G. Lyle	Glenn C. Dowell
COSHOCTON	E. J. Booth	F. W. Craig
HARRISON	Carl F. Goll	D. L. Tippett
JEFFERSON	John Gallagher	S. L. Burkhardt
MONROE		
TUSCARAWAS	J. S. Adler	E. C. Davis, Jr.
EIGHTH DISTRICT		
ATHENS	Beatrice Postle	M. H. Mitchell
FAIRFIELD	L. E. Stenger	W. M. Kuntz
GUERNSEY	Robert A. Ringer	B. S. Gillespie
LICKING	George A. Gressle	J. B. Johnson
MORGAN	Henry Bachman	A. A. Coulson
MUSKINGUM	George C. Malley	Paul Jones
NOBLE	Edward G. Ditch	N. S. Reed
PERRY		
WASHINGTON	Donald S. Williams	R. M. Meredith
NINTH DISTRICT		
GALLIA	Charles E. Holzer, Jr.	Jacob Weinberger
HOCKING	C. T. Grattidge	H. M. Boocks
JACKSON	John L. Frazer	Earl J. Levine
LAWRENCE	Newton Spears	George G. Hunter
MEIGS	E. F. Maag	Roger P. Daniels
PIKE		
SCIOTO	O. D. Tatje	W. M. Singleton
VINTON	H. D. Chamberlain	Richard E. Bullock
TENTH DISTRICT		
DELAWARE	George J. Parker	Edward C. Jenkins
FAYETTE	J. E. Rose	J. H. Persinger
FRANKLIN	Charles W. Pavey	Anthony Ruppersberg
	F. C. Hugenberger	George F. Collins
	Phillip T. Knies	Clark P. Pritchett
	Richard L. Meiling	Reuben B. Hoover
	Gilman D. Kirk	Thomas E. Rardin
	Robert E. S. Young	
KNOX	Henry T. Lapp	Raymond S. Lord
MADISON	Wm. T. Bacon	H. E. Karrer
MORROW	J. P. Ingmire	C. S. Jackson
PICKAWAY	E. L. Montgomery	E. S. Shane
ROSS	Ralph W. Holmes	Harold M. Crumley
UNION		
ELEVENTH DISTRICT		
ASHLAND	R. J. Ferguson	M. A. Shilling
ERIE	Ross M. Knoble	H. W. Lehrer
HOLMES	N. P. Stauffer	A. J. Earney
HURON	Owen J. Nicholson	Wm. H. Kauffman
LORAIN	Leonard A. Stack	A. F. Piraino
	Russell Arnold	G. R. Wiseman
MEDINA	Wm. Dwyer	A. J. Karson
RICHLAND	P. A. Blackstone	W. H. Buker
WAYNE	Lyman A. Adair	Harold G. Beeson

OFFICERS

Pres. ——— Carl A. Lincke
Pres.-Elect ——— E. O. Swartz
Treas. ——— H. P. Worstell
Past-Pres. ——— A. A. Brindley

COUNCILORS

District		District	
First	D. W. Heusinkveld	Seventh	R. J. Foster
Second	Merrill D. Prugh	Eighth	Chester P. Swett
Third	J. Craig Bowman	Ninth	J. P. McAfee
Fourth	Carll S. Mundy	Tenth	H. M. Clodfelter
Fifth	Fred W. Dixon	Eleventh	John S. Hattery
Sixth	Paul A. Davis		

Auxiliary's Annual Meeting . . .

Wives of Doctors Invited To Attend Business and Social Functions In Cleveland Concurrent With Annual Meeting of State Association

WIVES of all physicians who attend the Annual Meeting of the Ohio State Medical Association are invited to attend both the business sessions and the social functions being planned for the Tenth Annual Meeting of the Woman's Auxiliary, May 16, 17 and 18, at the Cleveland Hotel.

Mrs. C. W. Kirkland, Bellaire, president, will preside at sessions of the Auxiliary. Co-chairmen of the Annual Meeting Committee on Arrangements are Mrs. Farrell Gallagher and Mrs. D. M. Keating, both of Cleveland.

Auxiliary Headquarters will be the Hotel Cleveland.

PROGRAM

TUESDAY, MAY 16, 1950

9:30 A. M.—Pre-Convention Board Meeting (Cleveland Hotel).

12:00 NOON—Luncheon of Board of Directors.

1:30 P. M.—Formal Opening Session—Auxiliary Members and House of Delegates.

Presiding—Mrs. C. W. Kirkland, President.

Invocation—Reverend Leroy Lawther.

Pledge of Loyalty—Mrs. John L. Stevens.

Address of Welcome—President of Cleveland Academy of Medicine.

Response—Mrs. George Wilcoxon, President, Stark County Auxiliary.

Minutes of Ninth Annual Meeting—Mrs. C. H. Bell.

Organization of Convention.

Introduction of Convention Chairmen—Mrs. Farrell Gallagher and Mrs. D. M. Keating.

Announcements.

Roll Call.

President's Address—Mrs. C. W. Kirkland.

Reports of Officers:

President-Elect—Mrs. George Cooperrider.
Vice-President—Mrs. Paul Woodward.
Recording Secretary—Mrs. C. H. Bell.
Corresponding Secretary—Mrs. R. H. McCommon.
Treasurer—Mrs. A. Paul Hancuff.

Reports of Chairmen of Standing Committees:

Finance—Mrs. E. Benjamin Gillette.
Legislation—Mrs. Carll S. Mundy.
Historian—Mrs. Fred Brosius.
Hygeia—Mrs. Paul A. Davis.
Organization—Mrs. George Cooperrider.
Program—Mrs. R. S. Fidler.
Publicity—Mrs. S. L. Meltzer.
Public Relations—Mrs. Farrell Gallagher.

4:00 P. M.—Time to shop and visit Exhibits.

WEDNESDAY, MAY 17, 1950

9:30 A. M.—Second Session: Auxiliary Members and House of Delegates.

Reports of Special Committees.

Report of Nominating Committee (First Reading).

Reports of County Auxiliary Presidents.

Special Recognition of new Auxiliaries.

12:00 NOON—"In Memoriam"—Mrs. Paul Woodward.



Co-chairmen of the Auxiliary's Annual Meeting Committee on Arrangements are Mrs. Farrell Gallagher (seated) and Mrs. D. M. Keating.

1:00 P. M.—Presidents' Luncheon—

Honoring: Mrs. C. W. Kirkland, State President; Dr. Carl A. Lincke, President, O.S.M.A.; Out-of-State Presidents and Presidents-Elect.

Other Special Guests: Advisory Council of Woman's Auxiliary to Ohio State Medical

Association—Dr. H. M. Clodfelter, Dr. Paul A. Davis, Dr. Chester P. Swett.

Guest Speaker—Dr. George F. Lull, Secretary and General Manager of American Medical Association.

3:00 P. M.—Round Table Discussion, "Questions and Answers" Period, with State Officers and Chairmen.

7:30 P. M.—Annual Banquet of Ohio State Medical Association.

THURSDAY, MAY 18, 1950

9:30 A. M.—Third Session.

Unfinished Reports of County Auxiliary Presidents.

Unfinished Business.

New Business:

Finance—Acceptance of budget.
Recommendations of Board.
Election of Delegates to National Auxiliary Meeting.
Report of Convention Chairmen.
Announcement of winners in Credits and Awards.

Report of Nominating Committee (Final Reading).

Election of officers.

Installation of officers—Mrs. V. E. Holcombe, Charleston, W. Va., President of National Auxiliary 1940-41.

Inaugural Address—Mrs. George Cooperrider.

Introduction of New Board—Mrs. George Cooperrider.

Courtesy Resolutions.

1:00 P. M.—Luncheon—

Honoring—Mrs. George Cooperrider, and Mrs. David B. Allman, President of the Woman's Auxiliary to the American Medical Association.

Adjournment.

Post Convention Board Meeting.

New Student Center at Athens Is Opened

Ohio University's new $500,000 Student Health Center was opened for use in January. It is the second step completed in a five-fold building program on the campus.

The center is of three floors and a basement. It has a 40-bed capacity with a limit of 50 in emergency. It is designed primarily for handling out-patient activities, but can accommodate students requiring hospitalization for a few days.

ARE YOU AND MEMBERS OF YOUR FAMILY REGISTERED TO VOTE?

Auxiliary Amendment Would Provide For Honorary Members

The following amendment to the By-Laws of the Constitution of the Woman's Auxiliary to the Ohio State Medical Association was voted on at the March 14 meeting of the Board and will be presented for approval at the Annual Meeting in Cleveland.

"Amendment to the By-Laws of the Constitution of the Woman's Auxiliary to the Ohio State Medical Association:

"To provide for Honorary Membership, amend Chapter I of the By-Laws by adding Section 5, to read:

"Members of the Woman's Auxiliary to the Ohio State Medical Association, who have rendered long and signal service may be eligible to become Honorary members by action of the House of Delegates upon recommendation of the Board of Directors.

"An Honorary member shall enjoy all the privileges of active membership without payment of States dues. The State Auxiliary shall pay the dues of such members to the National Auxiliary."

Mahoning Doctors Sponsor Student Contest on Voluntary System

The Mahoning County Medical Society announced an essay contest for college students of Mahoning County on the subject, "Why We Should Preserve the Voluntary System of Medical Care in the United States."

Any college student of Mahoning County whether he attends a local college or any college in the United States is eligible for participation.

The Health Education Committee of the Society is conducting the contest which is part of the local Medical Society's effort in bringing to the public data on certain aspects in medical practice and an over-all improved public understanding of medical problems. The Health Education Committee is headed by Dr. C. F. Gustafson with the following members: Dr. E. J. Reilly, chairman of Public Relations and Economics; Dr. W. M. Skipp, Legislative Committee Chairman; Dr. Stephen W. Ondash, chairman of Lay Education and Speakers Committee, and Dr. James Miller.

Judges of the contest are being selected and will be announced in the near future. They will be furnished with the copies of final essays and given two weeks to study them. Copies of the essays from which the judges make their selections will carry neither the name nor address of the contestants. All winners will be announced by the president of the Mahoning County Medical Society on May 15, 1950.

Rural Health Betterment . . .

Closer Cooperation With County Medical Society Committees Is Among Objectives of Farm Bureau Councils in 'Keeping Alive Longer' Program

FARM Bureau Advisory Councils, the grass-roots study groups organized throughout the State by the Ohio Farm Bureau Federation, dealt with the problem of "Keeping Alive Longer," in their December deliberations.

To stimulate discussion and to provide facts for consideration by the councils, the Ohio Farm Bureau published each month the "Advisory Council Guide," which is attractively printed in two colors and contains illustrations and lists of reference material for further information on the subject.

In the December issue the suggestion was offered that rural health is "not all that it should be," and that in spite of clean country air, fresh foods, and outdoor life, the cities have a better health record than do the rural communities. It was stated that "while the average length of life for men living in cities increased 40 per cent between 1900 and 1939, the increase for rural people was only 19 per cent.

"Now is the time," the guide advised, "for us here in Ohio to work together to improve rural health. There are ways to get good doctors and good hopsitals; ways to get adequate public health units to help us in the prevention of disease accidents and illness."

In an inventory of rural health conditions, it was said that cities are far ahead of rural areas in sanitation, housing and modern medicine and that "cities have most of the doctors, dentists, the best clinics and modern hospitals."

"Black Marks" which will have to be wiped out in rural areas if we are to have a healthy America, according to the publication, are the following:

Preventable deaths, to which rural areas contribute "more than their share"; accidents, which "are more prevalent in rural areas"; lack of physicians, nurses and dentists; shortage of hospitals; need for better sanitation; and substandard nutrition in the country.

OHIO RANKS 48th

It was pointed out that Ohio ranks 48th among the states in per capita appropriations for its State Health Department, providing only nine cents per person in contrast with the $1.36 appropriated in New York.

Surveying "what we have" and "what we need," the folder contained suggestions that although we have legislation allowing us to set up efficient local health departments, we need to take advantage of the legislation and get large enough health districts to support fully staffed health departments.

It was stated that there is a well-planned health course for high schools as prepared by the State Departments of Health and Education, but that only 200 high schools of the 1,337 have the course in the curriculum.

The publication made reference to physicians appointed by County Medical Societies in most counties to work with schools and health departments on school health programs. "We need to help these doctors and our health commissioners and school superintendents to get together on a more effective school health program," the statement continued.

Reference also was made to County Medical Society Rural Health Committees, with the advice that "we need to work more closely with these doctors and to meet our rural health needs."

Cooperation with the local health department in getting well-child conferences was listed as a need. The suggestion was emphasized that each county have an active Farm Bureau Home and Community Committee to find out what the health problems are and to carry out activities and projects to improve them.

Attention was called to the fact that the Ohio Farm Bureau Federation has a group hospitalization plan which is widely used. It was stated that "a bill is now before Congress which would provide compulsory health insurance. There is also a bill before Congress which would provide more money for better public health departments and hospitals." The question was asked, "Which of these bills do you think we should support?" In this connection six reasons were given as to why many doctors oppose compulsory health insurance, and in conclusion it was asked, "Can we solve the rural health problem ourselves or do we need compulsory health insurance?"

According to a digest compiled from the minutes of the December meetings with 295 councils reporting, better health was the unanimous plea; there was voiced a definite need for more doctors and nurses; and compulsory health insurance was definitely voted down by all.

ARE YOU REGISTERED TO VOTE?
IF NOT, ACT PROMPTLY



SPACE STILL AVAILABLE ON OHIO STATE MEDICAL SPECIAL TRAIN TO SAN FRANCISCO NEXT JUNE; BETTER HURRY

ARE you interested in a grand, all-expense trip of three weeks to the Pacific Coast next June when the A. M. A. will meet in San Francisco? The Ohio State Medical Association is planning to run a special train. Space still is available. All rooms on the train have been assigned but LOWER AND UPPER BERTH ACCOMMODATONS ARE AVAILABLE. Those interested should write the Columbus Office of the Ohio State Medical Association immediately for complete details, costs, itinerary, etc.

The Special Train will leave Chicago, June 19 (providing the required minimum sign up for the trip) and will return to Chicago, July 8.

En route there will be sightseeing at Santa Fe, New Mexico; Grand Canyon; Riverside, Calif.; and Los Angeles (two nights and two days in that city).

Five days will be spent in San Francisco to permit all to attend the annual session of the American Medical Association.

Coming home, the Special Train will visit the following for sightseeing and entertainment: Portland, Oregon; Victoria, British Columbia; and Glacier National Park (three nights and three days in the Park).

The railroad accommodations will be first-class, standard, air-conditioned equipment. Excellent hotel accommodations will be provided in Los Angeles, San Francisco, and Glacier Park. Plenty of sightseeing, fun and entertainment will be provided. The cost is reasonable.

APPLICATIONS FOR SPACE WILL BE HANDLED ON A FIRST-COME, FIRST-SERVED BASIS UNTIL ALL REMAINING SPACE—LOWER AND UPPER BERTHS—HAS BEEN SOLD.

Better write in at once if you want to make this excellent vacation trip.

County Officers Conference . . .

Medicine's Stake in the Legislative and Political Fronts Is Theme At Columbus Meeting; Organization and Individual Goals Are Outlined

THE Annual Conference of County Medical Society Presidents, Secretaries and Committeemen, sponsored by the Ohio State Medical Association, drew nearly 200 persons to Columbus on Sunday, March 5, where distinguished speakers discussed matters of vital importance to the medical profession.

Dr. Carl A. Lincke, Carrollton, President of the Association, explained the three-fold purpose of the conference: First, to take an inventory of some of our major current activities; secondly, to discuss events and developments which are of vital concern to all physicians, not only as physicians but as citizens; and thirdly, to lay plans for future activities and actions.

GOALS

Dr. Lincke pointed out that the Ohio State Medical Association is a federation of 88 county medical societies, and that the end results of the medical profession's program in the long run will depend on what actions local societies take.

Following are briefs of some of the goals of the Association as Dr. Lincke enumerated them:

To improve and expand the "excellent" public education program, especially in getting every society and every member active;

To get every member to take an active interest in political, civic and community affairs;

To expand the fine work now being done by the Committee on Rural Health;

To develop a more active school health program under guidance of the Committee on School Health with the help of similar committees in each society;

To expand the present provisions for supplying speakers for medical society programs;

To continue to give active and financial support to the Ohio Committee on Public Health and to the Ohio Rural Health Council;

To promote more vigorously activities on behalf of Ohio Medical Indemnity, with the hope of having a million persons covered with prepaid medical expense by the end of the year;

To provide more active field service from the Columbus Office to the County Medical Societies;

To establish a Committee on Chronic Illness.

To continue to expand contacts with various state and Federal agencies engaged in activities involving services of physicians.

Dr. Lincke explained that the goals mentioned are only a few highlights in the over-all program of the Association and that the summary did not make any attempt to include the many services now being carried on by the state organization.

"YOUR A. M. A."

Dr. Edward J. McCormick, Toledo, member of the Board of Trustees of the A. M. A., issued a challenge to every doctor to participate in a program which he described as rendering to the public and to its members more than any other program of a similar organization.

Criticism of and lack of participation in the A. M. A.'s educational program by some members are based on misinformation or lack of information on the part of doctors as well as on the part of persons in other walks of life, the speaker said.

Probably not 50 per cent of doctors know what the program of the medical profession "is all about," Dr. McCormick challenged. He emphasized that the present campaign against compulsory health insurance is merely an expansion of the constantly growing program of the A. M. A. and component organizations.

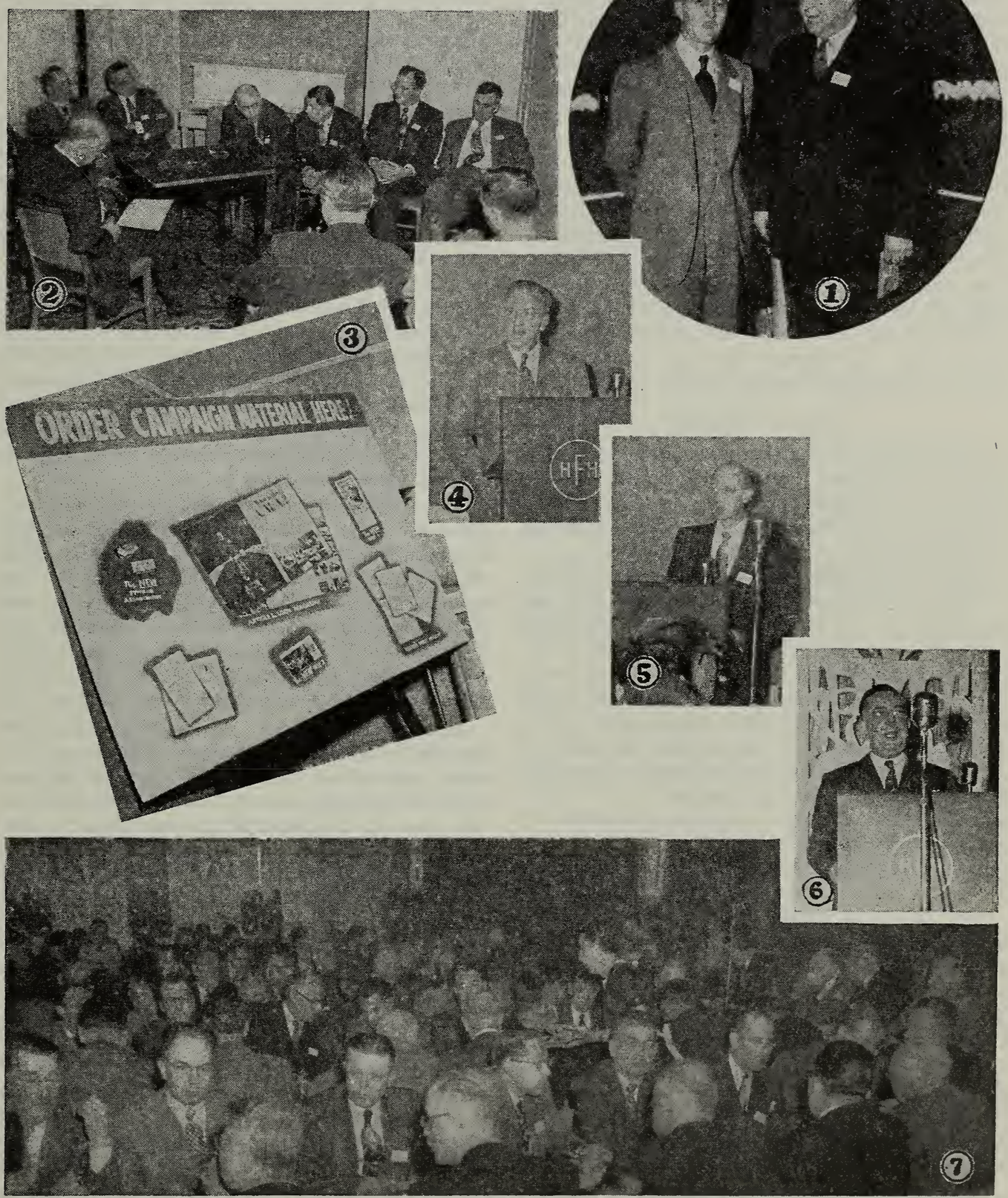
Dr. McCormick then reviewed some of the services of the A. M. A. Twenty-four councils, bureaus and permanent committees, supplemented by a full-time staff of more than 800 persons, are constantly supplying information and rendering services to the profession and to the public. Such an extensive program of services, he stressed, has not been attempted by any other organization.

Prior to 1949, Dr. McCormick pointed out, all of the services of the A. M. A. were carried on without any dues being paid by its members. The A. M. A. was supported largely by revenues from its publications and from fellowship dues, which in fact covered the subscription rate of *The Journal of the A. M. A.*

In 1948, he continued, it became evident that the A. M. A. would have to expand its public relations program to counteract the multimillion dollar propaganda programs of those who would destroy the free practice of medicine.

The speaker pointed out that the $25 annual dues of the A. M. A. had been voted according to the most liberal democratic principles. The House of Delegates first voted the $25 assessment and a year later, for the first time in history, approved the $25 annual dues. He confessed, however, that press relations on both of these occasions were poorly handled, resulting in poorly slanted initial announcements. The dues themselves, he reminded, are much less than those

Candid Shots at Columbus Meeting



—O.S.M.A. Staff Photos

These photographs show a few activities at the Conference of County Medical Society Presidents, Secretaries and Committeemen. (See story beginning on facing page for details.)

1. William M. McCulloch, member of the U. S. House of Representatives (left), and Roscoe R. Walcutt, member of the Ohio Senate, pose before the meeting at which both spoke.

2. Members of the Fourth District hold a conference presided over by Dr. Carll S. Mundy, Councilor. Each district held a similar meeting.

3. Campaign material is always available for the asking.

4. Dr. Charles A. Doan, Dean, O. S. U. College of Medicine.

5. Paul Daugherty of the Ohio Chamber of Commerce.

6. Dr. Edward J. McCormick, member, Board of Trustees, A. M. A.

7. Some of the nearly 200 doctors who attended the meeting, enjoy luncheon at the Hotel Fort Hayes.

of many trade and other organizations which render much less service in return.

In regard to the national educational campaign being directed by Whitaker and Baxter, Dr. McCormick said that it is receiving nothing but favorable comments from legislators because they have been informed exactly what the program will include. The speaker emphasized that the plan is purely one of education and information. No representative of the A. M. A. ever has or ever will solicit the vote of a legislator, he assured.

In regard to the shortage of doctors, Dr. McCormick said that the A. M. A. is doing everything that it can to increase the supply of doctors while maintaining standards. He branded as ridiculous criticism that the A. M. A. had attempted to limit the supply of doctors. On the contrary, he affirmed, many professional organizations are now following the example of the A. M. A. in demanding that the standards be kept at the highest possible level.

SOLON PRESCRIBES

State legislative matters were reviewed by Mr. Roscoe R. Walcutt, Columbus, Republican Floor Leader in the Ohio Senate of the 98th General Assembly, in an address entitled "Solon Prescribes for Hippocrates."

After a stimulating talk in which Mr. Walcutt reminded doctors of their political and civic responsibilities, the seasoned legislator enumerated some ways through which members of the medical profession can exercise their duties as citizens:

Doctors should encourage legislators who stand up for the interests of the public and doctors in matters of medical and health legislation;

Doctors should appear and express themselves when a health or medical matter is up for discussion before a House or Senate Committee;

Doctors should make their wishes known to county political party committees, which are the grass roots of national trends;

Doctors by all means ought to vote (he characterized as "terrible" the profession's voting record);

Doctors should belong to a political party and should take part in politics.

Mr. Walcutt complemented the Association's representatives in legislative matters for their "fairness and honesty" in discussing medical and health matters with legislators. He reminded doctors, however, that lay workers cannot be expected to work alone in respect to legislation.

The speaker concluded his talk by saying that doctors can have more influence in molding public opinion than any other class of people and that they ought to use that influence.

DRUMS ALONG THE POTOMAC

Legislative developments on the national level were reviewed by Mr. William M. McCulloch, Piqua, member of the House of Representatives, 81st Congress, Fourth Congressional District, in a talk entitled, "Drums Along the Potomac."

Mr. McCulloch predicted that the provisions of the compulsory sickness insurance proposals would not be passed in this session of Congress, and that they would not be passed at any time "if the medical profession will assume the duties which naturally fall upon it" as protectors of the people's health.

He reminded his audience that some of the provisions for Federal aid in the field of health and medicine already have been passed, and predicted that still others would be passed.

Provisions for more extensive medical research has an even chance of passing, he said.

The hospital survey and construction act (Hill-Burton Law) recently has been extended.

Federal aid for rural health provisions is under consideration.

An extensive research project into the field of children's health has been made, and proposals for Federal aid along this line will be made, he predicted.

Serious consideration is being given toward Federal grants to medical schools, he said.

Mr. McCulloch acknowledged that the general trend seems to be toward what he terms "the illusion of security in contrast to the fundamental idea of personal and individual liberty." He bemoaned the observation that most of us are too busy pursuing the "goddess of getting on" to do our duty to the state. In the end, he said, we will lose something much more important than the material interests we are striving for.

Among other legislative matters which he reviewed was that of the proposed Federal aid toward education. The speaker branded the proposed $300,000,000 Federal aid to education as "the nose of the camel in the tent door."

SOCIAL SECURITY

"Facts and Figures on the 'Welfare State'" were presented by Mr. Paul Daugherty, Columbus, director of the Legislative Department of the Ohio Chamber of Commerce. Mr. Daugherty summarized legislation in the field of social security, and asserted that all social security programs start small and grow big. To substantiate this observation, he pointed out that in 1935 old age benefits in Ohio were paid on the basis of a maximum of $30 per month, half of which was contributed by the Federal government. In 1948 the amount had been raised to $50 with the Federal share proportionately higher.

Commenting on H. R. 6000, which contains proposed expansion of the present social security benefits, Mr. Daugherty said that the bill if passed would extend the number of persons receiving old age and survivors' insurance to about eleven million. In addition to liberalizing coverage in almost every phase, he said, it would

increase the wage base for payroll deductions from the present $3,000 to $3,600 and perhaps to $4,800.

If the provisions of H. R. 6000 are put into effect, the speaker estimated, by 1980 the amount going out for old age, survivors' and disability benefits will be about $8,400,000 or 6 per cent of the payroll. Mr. Daugherty pointed out that this bill is entirely separate from any compulsory health insurance proposals.

The speaker said that the provisions of the bill follow the trend of the welfare state toward doling out benefits on the basis of so-called "needs" rather than on the basis of the employee's contributions as provided in original proposals of social security programs.

MEDICAL EDUCATION

Dr. Charles A. Doan, Columbus, dean of the Ohio State University College of Medicine, addressed the conference on the subject, "Problems Confronting Our Medical Schools."

Reviewing the needs of medical schools, Dr. Doan said that the combined annual budgets of the 79 schools operating at present, amount to about $53,500,000—an amount that is small in comparison to expenditures in less urgent fields. Of that amount, he revealed, there is a present deficit of around $9,500,000. Forty-eight medical schools are financially in the red. Only eight have resources sufficient to carry on their present programs, without allowance for expansion. The average school, of those not on a sound financial basis, needs between $100,000 and $400,000 per year to carry on, again without considering expansion.

Contrary to certain reports that medical schools are not advancing, Dr. Doan pointed out that while in 1910 there were 66 Class A medical schools, today there are 79. In 1930 there were 21,000 students in medical schools while today there are 24,800. In the last 40 years, he said, the number of students in medical schools has doubled.

Summing up where he considered responsibility rests for support of medical education, Dr. Doan specified these sources: Private benefactors with small or large contributions to supplement community enterprises; state appropriations; private foundations such as the heart fund; certain industrial corporations which are taking many doctors out of other fields for their industrial health programs; and the Federal government which requires the talents of many doctors both in time of war and of peace.

THE JOB AHEAD

In a stimulating talk at the conclusion of the meeting, Dr. E. O. Swartz, Cincinnati, President-Elect of the Association, spelled out some suggested methods for county medical society officers and committeemen to promote the interest of free medicine. Highlights of his suggestions included the following:

To get physicians registered and do everything possible to get them to vote;

To supplement the work of professionals in promoting election of public officials who have the interest of the people at heart;

To convince doctors that they have a stake in the election;

To remember that candidates for all political offices are important—not only those on the national level;

To support those legislators and other public officials who have stood up for the interests of medicine;

To promote a vigorous legislative committee in each county society;

To remember that candidates are human and are easier to talk to before elections than afterward;

To let legislators know how doctors stand on legislative matters.

Dr. Swartz pleaded for a more vigorous effort on the part of county societies to curb the minority of doctors who are bringing discredit on the profession. Some societies, he pointed out, have taken action on the rebate question. A number have set up systems to take care of emergency and night calls. Others have established committees to arbitrate differences between patients and doctors.

DISTRICT CONFERENCES

An important phase of the conference was that part of the program in which doctors of respective districts got together and discussed local problems and exchanged ideas.

A. M. A. Joins in Formation Of Health Committee

Six national associations, including the A. M. A., have formed the Inter-Association Committee on Health.

The associations, besides the A. M. A., are the American Dental Association, American Hospital Association, American Nurses Association, American Public Health Association and the American Public Welfare Association.

The committee will serve as a means for the exchange of information on the health programs of the participating organizations to the end that a common understanding may be reached toward the solution of national health problems. The committee will carry on activities contributing to the major objectives of improving the health of the nation.

ARE YOU REGISTERED TO VOTE?
IF NOT, ACT PROMPTLY

Ohio Academy of General Practice Supports $25 A. M. A. Dues

Following is a resolution which was drawn up by the board of directors of the Ohio Academy of General Practice, February 22, at the St. Louis Annual Scientific Assembly of the American Academy of General Practice, and forwarded to *The Journal* by Dr. Earl D. McCallister, Columbus, secretary-treasurer of the Academy. Dr. McCallister reported that the resolution was passed by unanimous vote of the Board of Directors, the state officers, and approved by other members present.

"Whereas, the American Medical Association has always been and continues to be recognized as the Mother Medical Association, and

"Whereas, this honored and respected Association has existed up to the present on the remuneration from the *Journal* and minimum Fellows dues, and

"Whereas, the national, state and local independence in the practice of medical, surgical and other specialties is being threatened by socialized governmental form of medical care, even though the people of this nation have at their command the best medical care in the world, and

"Whereas, the American Medical Association has been forced to combat this national socialistic force by informing and educating the general public into the real meaning of socialized medicine by requiring each member to pay annual dues of twenty-five dollars with which to accomplish this duty and task, and

"Whereas, one of the requirements for active and continued membership in the American Medical Association is the payment of these dues, and

"Whereas, one of the requirements for admission and continued membership in the American Academy of General Practice is full and active membership in the American Medical Association, therefore,

"Be it resolved that the Board of Directors, state officers and state delegates of the Ohio Academy of General Practice assure the American Medical Association of its complete support and approval of the annual twenty-five dollar dues, and

"Be it further resolved that the Ohio Academy of General Practice will continue its present requirements for new or active membership of its members.

"(Signed) Board of Directors of the Ohio Academy of General Practice."

Dr. Jermyn F. McCahan, formerly medical director of Bausch & Lomb Optical Co., is the new assistant to Dr. Carl M. Peterson, secretary of the A. M. A. Council on Industrial Health. Dr. McCahan will travel extensively, visiting industries throughout the Nation.

Health Days Exhibits Again Sponsored In Akron by Auxiliary

The third annual Medical Health Days exhibits, sponsored by the Woman's Auxiliary to the Summit County Medical Society, were held February 17 and 18 in the O'Neil Department Store Auditorium in Akron.

Under the chairmanship of Mrs. Robert E. Brubaker and Mrs. J. P. Sauvageot of Akron, 37 organizations participated, including the Summit County Medical Society and the Ohio State Medical Association. The former organization sponsored an exhibit on bones and muscles secured from the American Medical Association Bureau of Exhibits, and in addition showed a panel which described the program of the society which guarantees to everyone the services of a physician any hour of the day or night, regardless of his ability to pay. Dr. A. S. McCormick of Akron provided a historical display of medical developments in Summit County and medical literature.

The display of the Ohio State Medical Association demonstrated the operation of the human respiratory system, use of the bronchoscope, and the nasopharyngoscope. Panels showed the anatomy of the lungs, description of pneumothorax, tuberculous lungs, silicosis, pneumonia, and other conditions. This exhibit also was secured from the American Medical Association. Attendants answered questions about the display and furnished literature on various health subjects. Mr. Hart F. Page, assistant director of the Department of Public Relations, was in charge of the exhibit.

To stimulate interest in the Medical Health Days program, Dr. W. W. Bauer, director of the Bureau of Health Education, American Medical Association, and editor of *Today's Health*, came to Akron February 6 and 7, where he addressed the students at South High School, Old Trail High School, Buchtel High School, West Akron Kiwanis Club, The Downtown Lion's Club of Akron, and talked at a tea given by the Summit County Medical Society Auxiliary. He also made several radio appearances.

See pictures on facing page.

Diseases of Chest

The Third Annual Postgraduate Course in Diseases of the Chest, sponsored by the American College of Chest Physicians, Pennsylvania Chapter, and the Laennec Society of Philadelphia, will be presented at the Warwick Hotel, Philadelphia, Pa., April 10-14. The tuition fee is $50. Applications should be sent to: American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

TO BE A GOOD CITIZEN, YOU MUST BE REGISTERED TO VOTE

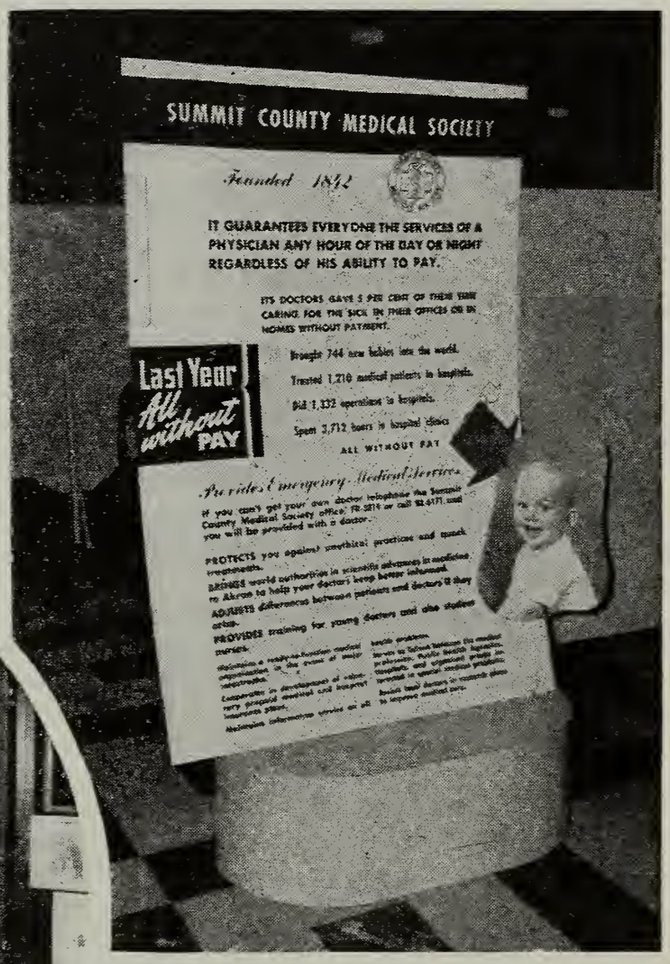
Health Days In Akron



Above is part of the Summit County Medical Society's exhibit portraying in lay terms the growth of bones.

To the right is a chart which states that the Summit County Medical Society "guarantees everyone the services of a physician any hour of the day or night regardless of his ability to pay."

On this page are candid photographs taken during the third annual Medical Health Days exhibit sponsored by the Woman's Auxiliary to the Summit County Medical Society in Akron, February 17 and 18, in the O'Neil Department Store.







Pictures in the center circle and to the right are visitors inspecting the exhibit of the Ohio State Medical Association which demonstrated how a person breathes.

See story on facing page.

—O.S.M.A. Staff Photos.

A.M.A. Warns on 'Cold Cures' . . .

Public Is Advised That Indiscriminate Use of Antihistaminic Drugs Can Cause Toxic Reactions; More Accurate Research Being Conducted

A STATEMENT by the Council on Pharmacy and Chemistry of the A. M. A. on the effectiveness of antihistaminic drugs will be of particular interest to Ohio physicians, coming as it does immediately after a statement by the Food and Drug Administration, report of which appeared in the March issue of *The Journal.*

Effectiveness of these drugs in the prevention and treatment of colds has not been demonstrated by the reports on which a widespread promotion of "cold cures" is based, in the opinion of the Council.

In a lengthy report published in the February 25 issue of the *Journal of the A. M. A.*, and made public, the Council on Pharmacy and Chemistry holds that "the evidence so far presented should be properly classified as the honest opinion of the investigators and not as fact." It concludes: "Until a scientifically acceptable study is performed, the true effectiveness of the antihistaminic drugs in the control of the common cold cannot be evaluated."

As a guide for further investigations, the Council outlines a procedure which in its opinion "would be a true test of these agents in the treatment and prophylaxis of the common cold."

WARNINGS

Meanwhile, the Council is standing upon a warning which it issued to the press December 2, 1949. The warning had pointed out that records show that many people who take these drugs become drowsy or even fall asleep while at work or in occasional cases even when driving cars or operating machinery.

Reporting on toxic reactions and even death from overdosage, the Council in its current report adds the further warning:

"With over-the-counter sale, careless and habitual use of the antihistaminics may be expected and the medical profession should anticipate similar serious reactions. Basic research is indicated on the chronic toxicity of these agents in human subjects."

QUALIFIES RESEARCH RESULTS

The Council reviews the results reported by four groups of investigators. These reports covered 2,357 patients, more than one-half being studied by a single observer. Summarizing its analysis, the Council says:

"The diagnostic methods employed have not conclusively demonstrated that the condition treated was actually the common cold. Over half of the cases were investigated in studies with inadequate controls or even without controls, and the interpretations of the results are open to question."

It further says: "None of the studies established the diagnosis of a common cold beyond reasonable doubt. By exclusion of bacterial infection as a cause, one cannot arbitrarily assume that a virus is the agent responsible for the appearance of symptoms; allergy may be involved.

MANY SOURCES OF ERROR

"Acceptance of the patient's own diagnosis of a cold introduces many sources of error. The patient may have been mistaken in his belief that he was getting a cold; he may have been manifesting the symptoms of an allergy, or his 'cold' may have been aborted without the aid of any therapeutic agent. By physical examination alone, the cause of coryza certainly cannot be established as the virus of the common cold.

"Thus, in none of the studies is there clearcut evidence of a verified diagnosis of the common cold."

The Council adds that the prophylactic study of one group, "while suggestive, requires verification because the series is small and contrary to the experience of allergists." It points out that "the antihistaminic agents apparently produce considerable subjective relief owing to inhibition of nasal discharge. Similar results may be obtained by use of ephedrine or atropine."

OPINION, NOT FACT

Commenting on the studies as a whole, the Council says:

"The acceptance of claims for therapeutic or prophylactic value of antihistaminic agents in the common cold requires demonstration that the condition treated in the studies was the common cold. Validity of diagnosis and cure must not be left to the discretion of patients, and the interpretation of results should be unquestionable.

"The evidence so far presented should be properly classified as the honest opinion of the investigators and not as fact. The common cold is such an economic hazard that this opinion must be checked by more basic research in the pathogenesis (origin and development) of the disease and the toxicity of the drugs employed, as well as by more authentic clinical evaluation."

In detailing an investigation technique, the Council suggests the use of a large group of normal volunteers in whom allergy has been eliminated by history and proper tests. One-

third should be designated as the prophylactic group, another third as the treatment group and the remaining as a control.

MULTIMILLION BUSINESS

In an editorial comment on the Council's report, *The Journal* points out that it has been estimated that the sale of antihistaminic drugs this year may reach $100,000,000 and adds: "This is a plum for those who want to pluck it."

It says this "perhaps is one of the reasons for the ambitious selling program," which some of the promotors of antihistaminic drugs have launched in the face of warnings from medical authorities.

"Advertising is a part of our everyday life, and we accept it for what it is," says *The Journal.* "Properly employed it plays an important part in the marketing of goods, but drivel such as some of the pleas for over-the-counter antihistaminics should not be thrust on the American public. There is a limit to what the public should be asked to stomach. Nonsensical advertising does not benefit anyone except the seller, and even his benefits may be of brief duration if the advertising boomerangs.

"The current advertising splurges for over-the-counter antihistaminics do not bring credit to their promoters. Such puffery should be controlled sensibly and on a voluntary basis. If this is impractical, however, enforcement agencies should not hesitate to meet their responsibilities. The moral obligations for those who supply services to the public should be self-evident to all interested parties. When health is included in these services, the moral obligations assume even greater significance."

A. M. A. Witnesses Point Flaws In Disability Clause

Three official spokesmen have presented A. M. A.'s arguments against the permanent and total disability clause of H. R. 6000, social security extension bill. They are Dr. James E. Paullin of Atlanta, Ga., Dr. R. L. Sensenich of South Bend, Ind., and Dr. Gunnar Gundersen of La Crosse, Wis., who testified February 28 before the Senate Committee on Finance.

They stressed three points: 1. Determination of permanent and total disability would strain the relationship between physician and patient. 2. This clause would put a cash premium on malingering and deprive patients, perhaps unconsciously, of the "will-to-recover," recognized as an important therapeutic factor. 3. Restrictions would inevitably be relaxed, bringing more and more people under the benefits and stimulating socialized medicine.

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FOR YOUR PATIENTS:

Order the following campaign materials for your waiting room. Make the facts on Compulsory Health Insurance readily available to your patients.

Title	Quantity
Booklet: "The Voluntary Way Is the American Way" (Revised 1950) . .	----------
Booklet: "You and Socialized Medicine"	----------
Folder: "Keep Politics Out Of This Picture" (Revised 1950)	----------
Assortment of Stickers for Your Correspondence (Revised 1950) . .	----------

Mark quantity desired and mail this blank to Ohio State Medical Association, 79 E. State St., Columbus 15, Ohio.

Name ----------

Address ----------

City ----------

Health Service To Study Radiological Hazards

Formation of a new unit under the Public Health Service, Federal Security Agency, to develop a radiological health program to meet potential health hazards created by increased use of radioactive materials and radiation-producing machinery has been announced.

Established within the recently formed Engineering Resources Division of the Public Health Service, the new unit is known as the Radiological Health Branch and is under the direction of Dr. Edwin G. Williams, a Public Health Service medical director.

The Radiological Health Branch will correlate radiological health activities in the Public Health Service, develop a training program in radiological health for Service officers and other public health workers, and act as a source of information on radiological health for other units of the Service, for other Federal agencies, and for State and local health agencies.

Surgeon General Leonard A. Scheele of the Public Health Service said the new branch was established "because of the recent rapid increase in the use of radioactive materials and radiation-producing machines in hospitals, industry, experimental laboratories and other places throughout the country."

"This in turn," Dr. Scheele said, "has created a need for some consideration in the Nation's public health program of the control of potential radiation hazards."

Cancer Campaign . . .

Efforts of Physicians and Laymen Toward Education of Profession And Public Will Culminate in April Drive; Ohio's Goal is $850,000

APRIL has been designated by act of Congress and by Presidential proclamation as Cancer Control Month. Those closely associated with the fight against this disease, however, like to point out that the approaching campaign is only the climax of eleven months of intensive education and service activities by county units of the American Cancer Society.

All physicians of Ohio are being urged to actively participate in the 1950 Cancer Control program. The Ohio State Medical Association took an active part in organizing the Ohio unit of the American Cancer Society. Prominent members of the Association have been, and still are, members of its executive committee which is in charge of setting policies and administering activities of the Ohio unit.

Repeatedly The Council of the Ohio State Medical Association has urged county medical societies and individual physicians to take part in cancer control work, to cooperate with the county cancer societies and to guide them in their activities.

GOAL IS SET

The national goal this year is $14,500,000 with Ohio's share set at $850,000. Governor Frank J. Lausche is lending support to the Cancer Society's efforts as honorary chairman for this year. Paul A. Warner, Mount Vernon, is campaign chairman and Don H. Ebright, Columbus, co-chairman.

Mr. Warner sounded the keynote of the campaign when he said: "Greater public interest in regular physical examinations is the ultimate goal of the thousands of volunteers who are trying to reach every person directly with the facts about cancer. We view this effort in April as a powerful educational program, and we view the problem of cancer control as a medical problem."

In each county, Mr. Warner pointed out, there is a Medical Advisory Committee appointed by the County Medical Society serving with the county unit to guide that unit in its cancer control efforts.

"A great deal of credit should be given to the members of the Ohio State Medical Association and the County Medical Societies," Mr. Warner continued, "because without their guidance cancer control in Ohio would not be at its comparatively high point of attainment. Our State, with less than five per cent of the national population, has 12 per cent of the country's detection and diagnostic services. Medical facilities have been improved in many areas by the addition of necessary equipment, establishment of cytology laboratories, institution of detection and diagnostic services and loan cabinet projects."

DOCTORS PLAY KEY ROLES

Mr. Warner praised the work of Dr. Carl A. Wilzbach of Cincinnati, president of the Ohio Division of the American Cancer Society; Dr. J. H. Lazzari, Cleveland, chairman of the Service Committee; Dr. C. E. Hufford, Toledo, chairman of the Professional Education Committee, and Dr. M. M. Zinninger, Cincinnati, chairman of the Lay Educational Program Committee. "With the help of members of their committees, these doctors have helped us steer a course in sound cancer control within the State of Ohio," Mr. Warner said.

As part of the Professional Education work in Ohio, the Ohio Division underwrote the cost of the National Radiological Society meeting held several months ago in Cleveland, as well as the cost of brochures giving the latest data on cancer to medical men. Under Dr. Zinninger's direction, 13 training schools for volunteers were held in the State so that volunteers might be better equipped to interpret the urgencies of early examination, as well as a sound attitude toward cancer as a problem of the layman. Seventy-two counties were represented by more than two thousand workers at these training schools.

"We all realize that the answer to cancer will come from science and the marshalling of all scientific disciplines to bear on the problem," Mr. Warner concluded. "The cancer program in Ohio is designed to help science to help the average man."

Northwest Health Officers Meet

An organization meeting of the Northwest District of the Ohio Public Health Association was held January 27 in Findlay, at the call of Dr. F. E. Mahla, health commissioner of Lucas County, president.

Dr. Carll S. Mundy, Toledo, Councilor of the Fourth District of the Ohio State Medical Association, and chairman of the Association's Committee on Rural Health, spoke on "Rural Health Programs in Ohio and the Nation."

Dr. John D. Porterfield, director of the Ohio Department of Health, opened the general discussion on the purposes and values of regional public health conferences.



Extensive mucosal destruction and ulceration from chronic ulcerative colitis with only a few inflammatory polyps.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

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IN COLITIS MANAGEMENT—In the constipation of spastic, atonic and even ulcerative colitis, the smoothage action of METAMUCIL is of proved value.

METAMUCIL® provides a bland, soft bulk with a tendency to incorporate irritating particles with the fecal residue and is thus a valuable adjunct in correcting the constipation and minimizing irritation of the inflamed mucosa. METAMUCIL is the highly refined mucilloid of a seed of the psyllium group, Plantago ovata (50%), combined with dextrose (50%).

Deans Report on British System . . .

Three Medical College Heads Return From Study of Medical Practice In England and Declare That Socialization Was Move of Desperation

SOCIALISM in Great Britain, its welfare state and its nationalization of medicine are measures of desperation "and should not be regarded as an expression of evolutionary social and economic advance to be widely emulated by more fortunate nations."

This opinion is expressed in a report to the Board of Trustees of the American Medical Association after two months' study of medical practice in England under the National Health Service Act, by three American medical school deans, one of them, Dr. Stanley E. Dorst, dean of the University of Cincinnati College of Medicine. The other two are Dr. Harold S. Diehl, Minneapolis, dean of medical sciences, University of Minnesota Medical School, and Dr. Loren R. Chandler, San Francisco, dean of Stanford University School of Medicine.

The report traces the development of socialism in England to changing economic conditions. It points out that the population of Britain has been growing while its "market has shrunk to a shadow of its former greatness." Furthermore, it adds, the impact of the war has left that country in desperate circumstances.

"It should be understood," the deans report, "that with the end of World War II only the state controlled the money necessary to maintain and operate the hospitals of Britain; to finance the medical schools and promote medical research and to provide medical care for approximately two-thirds of the people.

OUR METHODS EVOLUTIONARY

"When these facts are fully comprehended it seems clear that what is necessary and perhaps admirable in Great Britain may be unnecessary and even undesirable in the United States. Whereas Great Britain resorted to revolutionary methods to meet a critical emergency, we are still fortunate enough to have the opportunity to work out our problems in a wise way, employing evolutionary methods."

During the war the British government subsidized hospitals frequently to the extent of half of operating costs, the report points out, adding:

"When these subsidies were discontinued in 1946 most of the hospitals were insolvent. Faced with the very real danger of hospital closure on a nationwide scale it became apparent that large grants from public funds designed for hospital expenditure must immediately be forthcoming or rapid disintegration of the hospitals of Great Britain would occur.

STUDENT SUBSIDIES

"Not only were state funds essential to the continued operation of hospitals but a five-fold increase in public money was needed for the medical schools. Concurrently, scholarships and grants to medical students from public monies were enormously increased, for the difficult economic conditions prevented all but the children of wealthy persons from matriculation in medical schools.

"Before the war approximately 20 per cent of medical students received financial aid. Now at least 80 per cent are receiving educational grants or scholarships, mostly from government sources."

Under the National Health Service Act which went into effect in July 1948, the Ministry of Health took over all the hospitals in Great Britain. All patients are hospitalized free of charge, the operating costs and capital expenditures being provided through the budget of the ministry.

"Since the adoption of the Act, the general practitioner no longer has hospital privileges," the report says. "Nor does he command the direct use of those ancillary departments which have become essential to good medical work, the clinical laboratory, X-ray facilities, etc. He must confine his activities to home calls and office visits, now almost entirely under the capitation-fee system.

GENERAL PRACTICE FRUSTRATION

"The frustration within the field of general practice which was beginning to become apparent under the old panel system has been greatly accelerated by the regulations of the Act."

As a result of this situation, the report adds, "the future of this backbone of the profession is in grave doubt." Under the capitation-fee system most of the practitioners are accepting the maximum of 4,000 patients to have a reasonably satisfactory income, the deans say. This was held to be excessive for best medical service.

Although the general practitioner can take postgraduate training at the expense of the

IF YOU'RE NOT REGISTERED TO VOTE,
VISIT YOUR ELECTION BOARD

Ministry of Health relatively few men are taking advantage of the opportunity, the deans found.

LASSITUDE IN TRAINING

"The reason most frequently given is that he cannot practice medicine under present restrictions any more effectively after he takes the course, so why take it," says the report. "The frustration of the man in general practice under existing circumstances is by far the most significant defect in British medicine."

It adds that the Act has practically destroyed all interest in training for the position of public health officer or administrator because of the limitation on scope of activities and the low salary in comparison with that which the physician in clinical practice can obtain.

"The source of the future full-time physician in the public health service is problematical," the deans say.

Also cited as a disturbing element is the tendency of medical students to study for the specialties rather than general practice because of the favored position of the specialists.

NATIONAL-LOCAL BUFFERS

In medical education and research, the deans say, "buffers have been devised to protect the traditional freedom from the immediate control of statism." This protection is through authority given the University Grant Committee, the Medical Research Council and the General Medical Council.

"It is most important to note that there is nothing analogous in the program of the American protagonists of state medicine," the report adds.

"It was the frank opinion of almost everyone with whom we conferred that it would be a tragic mistake not to establish a similar and equally effective buffer between the medical schools of the United States and the government if our schools are to have Federal funds to augment their budgets."

Concluding, with emphasis on "the all important social, economic and geographic background against which British socialism developed," the report says:

"The National Health Service Act is only one facet of British socialism. The welfare state does not exist except as a part of the whole. Conditions in Great Britain are so different from those in the United States that it is folly to contend that what may be necessary for Britain today should be admirable for transfer to the United States. We, fortunately, have the time which is necessary to evolve an adequate medical service for our people without resorting to the centralization of authority in a welfare state."

An Observation on the Accuracy of Digitalis Doses

Withering made this penetrating observation in his classic monograph on digitalis: "The more I saw of the great powers of this plant, the more it seemed necessary to bring the doses of it to the greatest possible accuracy."[1]

To achieve the greatest accuracy in dosage and at the same time to preserve the full activity of the leaf, the total cardioactive principles must be isolated from the plant in pure crystalline form so that doses can be based on the actual weight of the active constituents. This is, in fact, the method by which Digilanid® is made.

Digilanid contains all the *initial* glycosides from Digitalis lanata in crystalline form. It thus truly represents "the great powers of the plant" and brings "the doses of it to the greatest possible accuracy".

Clinical investigation has proved that Digilanid is "an effective cardioactive preparation, which has the advantages of purity, stability and accuracy as to dosage and therapeutic effect."[2]

Average dose for initiating treatment: 2 to 4 tablets of Digilanid daily until the desired therapeutic level is reached.
Average maintenance dose: 1 tablet daily.
Also available: Drops, Ampuls and Suppositories.

1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

Literature giving further details about Digilanid and Physician's Trial Supply are available on request.

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

FIGURES ON INERTIA OF CITIZENS, INCLUDING DOCTORS

One of the speakers in Chicago on February 12 at the Second National Conference on the A. M. A. Education Campaign, sponsored by the A. M. A., was Charles S. Nelson, executive secretary of the Ohio State Medical Association. Mr. Nelson described the activities of the physicians of Ohio in an election year with respect to interviewing candidates and arousing doctors to support worthy candidates. The part of his talk which made a deep impression on the audience was that which cited figures on the failure of physicians, businessmen, teachers, ministers, and others to vote or to even register so they can vote. Mr. Nelson also urged representatives of all states to return home and do a bit of checking to find out how much inertia there may be in their own states.

Here's what the A. M. A. *Secretary's Letter*, written by Dr. George F. Lull, had to say about the comments of Ohio's executive secretary:

"Physicians can't win their fight by staying away from the polls on election day, Charles S. Nelson, executive secretary of the Ohio State Medical Association, said at the Second National Conference on the A. M. A. Education Campaign in Chicago recently.

"Mr. Nelson provided some startling facts which show the medical profession's inertia at election time.

"'Let me give you some almost unbelievable data which have been uncovered in Ohio,' Mr. Nelson said, adding:

"'After the surprise party which Mr. Truman threw in November, 1948, some of the political leaders in Ohio decided to hold a postmortem. They selected one of Ohio's industrial areas—Summit County, including the city of Akron. The records of the county board of elections were scrutinized. Believe them or not, here are some of the findings:

"'18 per cent of the physicians of the county did not vote in the 1948 election—13 per cent of them were not even registered and therefore not eligible to vote.

"'22 per cent of the wives of physicians did not vote—16 per cent of them were not registered.

"'10 per cent of the members of the Rotary Club did not vote—3 per cent were not registered.

"'The tally on Kiwanis Club members was about the same.

"'18 per cent of the druggists did not vote—15 per cent were not registered.

"'11 per cent of the teachers did not vote—6 per cent were not registered.

"'32 per cent of the bank employees, including executives, did not vote—26 per cent were not registered.

"'33 per cent of the ministers did not vote—26 per cent were not registered.

"'34 per cent of the retail grocers did not vote—29 per cent were not registered.

"'Here's one for the books: 21 per cent of the members of the Chamber of Commerce did not vote—15 per cent were not registered.

"'I could give you additional statistics. However, these will suffice to show why we are bearing down on registration of voters and voting this year. We're sure that similar data could be uncovered in other parts of the state.

"'Elections are still won by votes, strange as that may seem to some people.

"'And, the politician still has a warm spot in his heart for groups which vote and produce votes. If you doubt that, just ask one,'"

ACTION CALLED FOR IN COLUMBIANA COUNTY

We suggest that the Columbiana County Medical Society step forward and take a bow as recognition for a resolution which the society adopted on Feb. 7, 1950, advocating an adequately financed, efficient public health set up for that county.

Doubtless, the public health program in that county is as good as programs in many other counties. Nevertheless, it isn't good enough to satisfy the medical society. So, it decided to do something about it.

Here's the text of the resolution which many other medical societies would do well to use as a model for similar action:

"1. Public health is one of the specialized branches of medicine.

"2. As a branch of medicine, public health becomes the specific and intent interest of the Columbiana County Medical Society.

"3. Public Health in Columbiana County has suffered because of lack of sound cooperative administration.

"4. The health departments of the county have not provided complete services of Public Health to the people of the county as recommended and required by the laws of the State of Ohio.

"5. Public health work in Columbiana County



During Pregnancy SALT WITHOUT SODIUM

Water retention (excessive gain in weight—pitting edema) is quite common in pregnancy. Sodium, particularly if used excessively, accelerates this process. Vice versa, sodium restriction can prevent water retention.

Neocurtasal, completely sodium free salt, palatably seasons low sodium diets. Neocurtasal looks and is used like ordinary table salt. Available in 2 oz. shakers and 8 oz. bottles.

Constituents: Potassium chloride, ammonium chloride, potassium formate, calcium formate, magnesium citrate and starch. Potassium content 36%; chloride 39.3%; calcium 0.3%; magnesium 0.2%.

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has been greatly retarded by the lack of cooperative support both officially and unofficially.

"6. The number of health districts in ratio to the distribution of population is unsound and unsatisfactory.

"7. The physicians of the county have not been able to participate actively in securing good public health for the people of the county because of the lack of organization and unification of the Public Health Departments of the county.

"Be it resolved that the following recommendations were made by the Columbiana County Medical Society, on February 7, 1950.

"1. That adequate working facilities, proper personnel and suitable quarters be made available to a centralized Health Department.

"2. That adequate amounts of money be budgeted and spent to secure good public health in the county.

"3. That all health districts of Columbiana County be fused into one strong Central Health Department as provided by the Laws of Ohio and recommended by the Ohio Department of Health.

"4. That the County Medical Society should advise, with the County Department of Health, on matters of a medical nature relative to public health.

"5. That the County Medical Society should have an active and representative committee on Public Health to study the needs and desires of the people.

"6. That the County Medical Society endorse and support a complete comprehensive public health program for the county.

"7. That a record of the action of the County Medical Society should be forwarded to the various responsible, official and interested agencies."

HOW TO PAY A. M. A. DUES AGAIN EXPLAINED

Misunderstandings regarding the payment of 1950 A. M. A. dues of $25.00 persist despite announcements made by the A. M. A. and the Ohio State Medical Association.

Remittances for A. M. A. membership dues **should not** be sent direct to the A. M. A. by county medical societies or by individual physicians. **They should be sent to the Columbus Office of the Ohio State Medical Association for forwarding to the A. M. A., and made payable to the Ohio State Medical Association.**

As soon as possible after dues are received from the State Association, the A. M. A. will send a membership certificate and pocket card to a member. This is being done now. However, thousands of dues are being received by the A. M. A. This requires detailed handling. Therefore, members are requested to be patient. They will get their certificates and cards just as soon as the A. M. A. can wade through this mass of paper work.

The A. M. A. Board of Trustees also has settled the controversial question of who is entitled to exemption from the payment of A. M. A. membership dues, as follows:

The county shall determine when the payment of dues is a hardship, but in no case will the A. M. A. dues be remitted unless the county and state dues also are remitted.

A person in actual training for not more than five years after his graduation from medical school will be exempted, provided he also is exempted from state and county dues.

The dues of a physician who joins his county society after July 1 will be $12.50; if he joins before July 1, his dues will be $25 for that year.

A physician who transfers from one state or county to another will not be expected to pay the dues a second time, but a physician must pay once.

The Constitution and By-Laws of the Ohio State Medical Association contain no provision for the exemption of members from paying state dues. Therefore, the above policies do not apply at this time to Ohio physicians. Authority to amend the Constitution and By-Laws is vested in the House of Delegates.

WHEN DISCARDING SAMPLES DO A COMPLETE JOB

The Post Office Department has requested physicians not to discard unwanted samples of medicine in wastebaskets at post offices, warning that children frisk these baskets for pictures and old stamps and might pick up samples which would be harmful if used.

Probably most physicians don't discard samples in post office wastebaskets. However, there is a warning here regarding the disposal of samples anyplace. They should be discarded in safe receptacles. They should not be left unprotected in office or home where adults, as well as children, can get them.

MOVE TO HELP TAXPAYER CAUSES LOUD WAILS

Congressional investigation of Secretary of Defense Johnson's consolidation of military hospitals and closing of some of them as economy measures as recommended by Ohio's Dr. Richard L. Meiling, director of medical services of the Office of Defense, has been making the newspaper headlines.

Some Congressmen are yelling bloody murder especially when the order affects their own districts. Naturally, the braid and the brass are howling. Johnson and Meiling contend the job can be done without impairing the efficiency and services of the medical department of the armed services. Prominent civilian physicians and others have jumped to the defense of Johnson and Meiling, including Dr. Raymond B. Allen, president, University of Washington, Seattle, Meiling's predecessor, whose statement said:

"I am deeply disturbed about Admiral Boone's attack on Dr. Meiling and the Armed Forces

Old at Forty

OR YOUNG AT SIXTY?



CLINICAL observation and nutritional science agree that much depends upon the diet whether the individual will be biologically old at forty or biologically young at sixty.

To extend biologic youthfulness and vigor into later years, a good nutritional state based on an adequate diet is mandatory at all times. The efficient functioning of many physiologic processes is involved in maintaining good nutrition. On the other hand, only the adequate diet can sustain these processes. To assure such dietary adequacy under many conditions of physiologic stress encountered in day to day living, a properly organized food supplement often assumes vital importance.

The *multiple-nutrient dietary food supplement* Ovaltine in milk richly provides many nutritional essentials when such supplementation is indicated. It provides excellent amounts of vitamins A and D, ascorbic acid, niacin, riboflavin and thiamine; the important minerals calcium, iron and phosphorus; and biologically complete protein. Its satisfying flavor and its easy digestibility make it widely useful in both general and special diets whether for children, adults, or the aged.

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PROTEIN	32 Gm.	VITAMIN B_1	1.16 mg.
FAT	32 Gm.	RIBOFLAVIN	2.0 mg.
CARBOHYDRATE	65 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12 mg.	COPPER	0.5 mg.

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

hospital unification program. As your former director and present member of your Medical Advisory Committee I strongly endorse your steps to achieve efficiency and economy by closing non-essential hospital facilities. This means better distribution for work load and more efficient use of personnel. Dr. Meiling, though young, is one of the ablest medical administrators in the country. My experience with him last summer confirmed my conviction that it would be most difficult to find anyone better qualified to do the job you want done in the medical area. If this attack succeeds in undermining Dr. Meiling or the Office of Medical Services the program of medical unification will be set back almost irreparably."

Who knows whether Secretary Johnson and Meiling will be able to make the order stick? It's the same old story of economy is o. k. for the other fellow; not for me. About time for someone to think about John Q. Taxpayer; or is that asking too much?

IT'S TIME FOR A HOUSE CLEANING

Some physicians are not going to like the statement issued recently by the Board of Trustees of the American Medical Association, taking the hide off those few doctors who charge excessive fees. Said the Board:

"The Board of Trustees looks with disfavor on the few members of the Association who charge excessive fees. It urges state and county societies to discipline those members who, after a fair hearing and a decision that the fees charged have been excessive, refuse to reduce their fees to a level that is reasonable for the services rendered."

Let those who object to the sentiments expressed above remember that the public will stand just so much; that the house cleaning will come either from within or without. Where the job should be done is apparent. Now will not be one minute too soon.

WHAT'S DOWN "THE ROAD AHEAD?"

In a recent editorial, labeled, "Our Road to Socialism," the *Cleveland Plain Dealer* said:

The Road Ahead is the title of a book by John T. Flynn in which the author tells how socialism came to Britain and in which he charges that socialist planners are trying to establish the same system in the United States.

This book is an arresting document. It describes how the government planners, without calling themselves socialists, have moved into the labor unions and the Democratic party to promote socialist objectives which are similar to those of the British Labor party.

The book can be secured from the publisher, The Devin-Adair Company, 23 East 26th Street, New York City, or at most book stores.

It's recommended reading for those who want the low-down on where we've been and where we seem to be going.

FORD MAKES ANOTHER SMART MOVE

Henry Ford did a lot of smart things in his time. Looks as if Henry Ford, 2nd, is a chip off the old block. Here's hoping more businesses with money in the bank will follow the lead of the Ford Motor Co., (and some other concerns, to be sure) described in the following story released by the Associated Press:

"The Ford Motor Co., wanting to discharge its obligations as an 'industrial citizen,' is setting up a special philanthropic organization.

"Formation of a new non-profit corporation, known as the Ford Motor Company Fund, was announced yesterday by Henry Ford II, president of the family-owned motor firm.

"Ford did not divulge the amount of money which the corporation, chartered under Michigan law, would handle. But he said that contributions would come 'principally' from the Ford company.

"The fund's purpose, he said, 'will be the alleviation of want and human suffering and the betterment of mankind.'

"It will make contributions 'in the fields of charity, education, public and private health and hospitalization, civic and community development,' he said.

" 'It is our observation,' he continued, 'that traditional sources of financial support of private institutions operating in these fields are tending to disappear.

" 'We do not like the consequences inherent in the alternative facing such private institutions—that of having to turn to government for much-needed financial aid.

" 'In our opinion, this situation places an increasing responsibility upon American businesses in their role of industrial citizens. ' "

DOCTOR SAYS FRIENDLY RIVALRY PUTS PHYSICIANS ON TOES

Dr. D. C. Houser of Urbana, former president of the Ohio State Medical Association, upon receiving the Association's 50-Year Pin and Certificate, made some pertinent observations in regard to free enterprise in the practice of medicine.

In an interview reported in the *Urbana Daily Citizen*, Dr. Houser modestly emphasized that any success he might claim as a doctor has been the result of community demands and good professional competition.

"They were good doctors, all good," he said, "and I had to either keep up with them or drop out."

Dr. Houser was reflecting the philosophy which has made doctors of today—both young and elderly—the best practitioners in the history of medicine.

How different from the proposed program of certain bureaucrats who would assign each doctor his place of practice, toss him a list of patients, clock him in at 8 in the morning and out again at 5 with an hour off for lunch—and let the patients be "jammed."



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Do You Know? . . .

Hospital Care Corporation of Cincinnati, which provides Blue Cross in a 14-county area, paid 100,555 hospital bills in 1949, amounting to $7,256,125.03 and covering 650,987 days of hospital care. Three most frequent reasons for hospitalization were: pregnancies, 22.8 per cent of all hospital admissions; injuries, 20 per cent; and tonsillectomies, 9.3 per cent.

* * *

Dr. A. A. Brindley, Toledo, Past-President of the Ohio State Medical Association, spoke on "Compulsory Health Insurance" at a public meeting sponsored by the American Legion, at Oak Harbor, February 20.

* * *

A total of 78 per cent of the country editors of America fear that our nation is headed toward Socialism, according to a poll conducted recently by *The American Press* magazine. Included in the group polled were over 500 weekly newspaper editors. Many believe that Congress' action on compulsory health legislation will determine whether or not we are "going socialistic." Opposition to this type of health legislation was expressed by 89 per cent of the editors.

* * *

Dr. Roger M. Gove, director of the Upper Miami Valley Guidance Center at Piqua and Troy since 1947, will become superintendent of the Columbus State School for the Feeble Minded, April 1.

* * *

Dr. Judson D. Wilson, Columbus, has been named a member of the Russell A. Hibbs Society of New York, in recognition of his outstanding work in the field of orthopedic surgery.

* * *

More than 72 per cent of the income of Cleveland's Lutheran Hospital last year was obtained through either non-profit or commercial forms of hospital insurance.

* * *

The 10,000th patient recently was admitted to the Central Ohio Rapid Treatment Center, which opened in January, 1946. The Center, located in Fort Hayes Station Hospital, Columbus, is administered by the Ohio Department of Health. It is supported by funds from the U. S. Public Health Service.

* * *

Dr. Louis H. Bauer, Chairman of the Board of Trustees of the American Medical Association, and Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, were guest participants in a round-table discussion entitled "What's the A. M. A. to Us and We to the A. M. A.?" during the 1950 Conference of County and State Officers of the Connecticut State Medical Society, March 16, at New Haven, Conn. Mr. Nelson also spoke on "The Doctor in Politics."

* * *

The activities and structure of the Ohio Rural Health Council were discussed by Mr. Hart F. Page, assistant director of public relations, Ohio State Medical Association on WRFD, the Ohio Farm Bureau radio station, February 27.

* * *

The Southwestern Ohio Society of General Physicians collaborated with the University of Cincinnati College of Medicine in presenting a series of round-table discussions on general practice, Tuesdays and Thursdays, 10 a. m. to 12 noon, March 2 through March 27, in the auditorium of the College.

* * *

George Richards Minot, M. D., for many years professor of medicine at Harvard Medical School, died recently at his home in Boston, aged 64, of coronary thrombosis and pneumonia. Dr. Minot won the Nobel Prize for his discovery of a cure for pernicious anemia.

* * *

Harvard Medical School has received a bequest of $500,000 from the late Paul V. Bacon, Wellesley, Mass., a textbook publisher, for research on the common cold.

* * *

"What is the Situation, Mentally Speaking?" was the topic discussed by Dr. Thomas E. Rardin, Columbus, at the annual county-wide Achievement Day Program of Champaign County, held at Urbana, March 17. The meeting was attended by several hundred women. The appearance of Dr. Rardin was arranged by the Woman's Auxiliary to the Champaign County Medical Society.

* * *

President Truman, on March 13, sent 21 reorganization plans to the Congress, but omitted the inclusion of a plan to establish a joint education, health and welfare department similar to the plan defeated by the Senate last year.

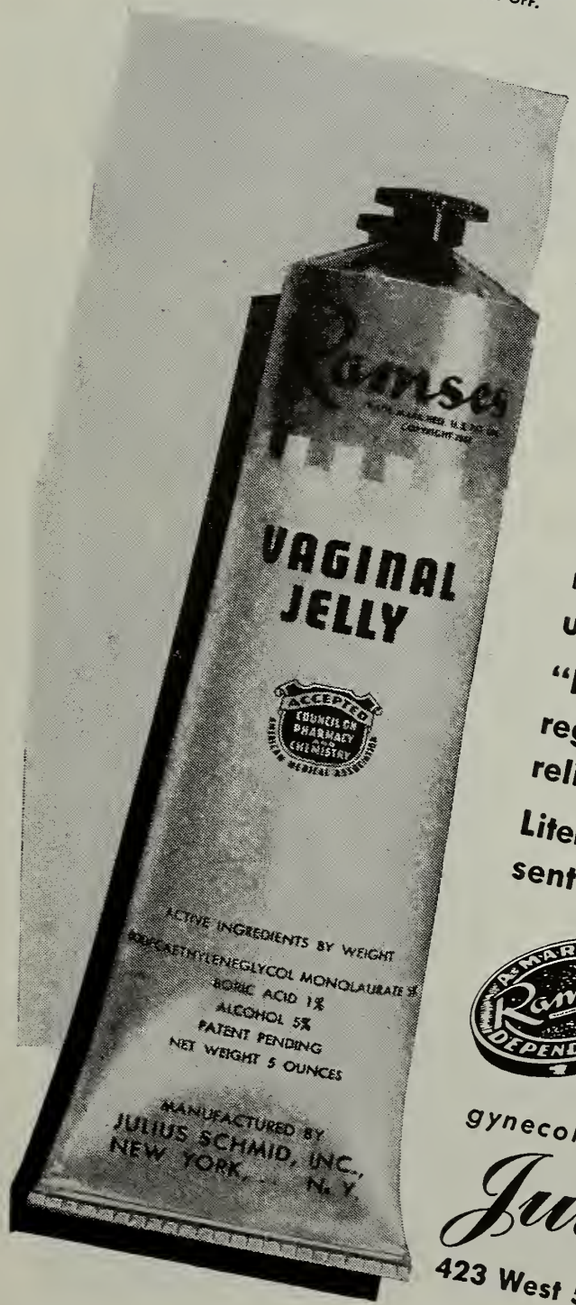
* * *

George H. Saville, Director of Public Relations, Ohio State Medical Association, recently addressed a class in "Community Health Organization" in the School of Social Administration of Ohio State University. He discussed national health legislation and explained the viewpoint of the medical profession on current issues in the health field.

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Shots at Truman-Ewing Compulsory Sickness Insurance Scheme; Ammunition For Doctors in Speeches Against Federalized Medicine

"If this state-guaranteed 'security' idea were new, it might help explain why so many people insist on trying it. But it is not new. It was written into the Code of Hammurabi over 4,000 years ago. In one form or another, it has been tried time and again throughout history—always with the same result. In the Roman Empire it was called 'bread and circus.' More recently, Karl Marx called it socialism."—*from Wards of the Government by Dean Russell, published by the Foundation for Economic Education, Inc.*

* * *

"The total cost of the National Health Service program for 1949-1950, including Scotland, is estimated at £352,324,600 . . . About six per cent of the cost is met by the individual. Approximately 94 per cent of the cost is met from general taxation. It is important to keep in mind that the National Health Service is not an insurance plan but almost entirely a direct government expenditure."—*The National Health Service of Great Britain, by Willard C. Rappleye, M. D., Vice-President in Charge of Medical Affairs, Columbia Universty.*

* * *

"I didn't get out of England because I couldn't make a dollar. I was making about 10 per cent more than before the program was put into effect. But I had 3,200 patients. I was making up to 36 house calls a day and seeing 60 or more patients in three one-hour office periods per day. That's an average of one patient every three minutes."—*Dr. Ralph J. Gampbell, self exile from England's socialized medicine program, quoted from the Journal of the Maine Medical Association.*

* * *

"The abrupt deterioration in the treatment of the sick is serious enough, but the effect of the British National Health Program on preventive medicine is tragic. Public health work, measures for the prevention of disease, either in existence or planned, have been retarded and even abandoned."—*Harold E. Stassen, President, University of Pennsylvania in Reader's Digest, for January, 1950.*

* * *

"Socialism is the syphilis of medicine. It is easy to take, but rots the body to death."—*Nashville Doctor.*

"While the theory of sickness insurance indicates its use as a powerful weapon in disease prevention, there is no indication that it has ever occupied this role. The efforts of the family physician in the field of alleviation are so increased (by it) that he commonly lacks the time to make the thoroughgoing examinations that result in an earlier discovery of a serious disease . . . the theory envisions but the practice inhibits."—*Sickness Insurance in Europe, by the late J. G. Crownhart, Madison, Wisconsin.*

* * *

"This most dangerous enemy is the American counterpart of the British Fabian Socialist, who denies that he is a Socialist and operates behind a mask which he calls National Planning."—*John T. Flynn's book, The Road Ahead, as condensed in the February, 1950, issue of Reader's Digest.*

* * *

"There are 78,000,000 life insurance policyholders. As money becomes cheap, their security vanishes. A $10,000 policy paid up in 1940 has lost $4,000 or more in terms of what it will buy today."—*Hon. Samuel B. Pettengill, former Congressman from Indiana, in an address October 12, 1949.*

* * *

Socialized medicine makes doctors responsible to politicians first—and their patients second.

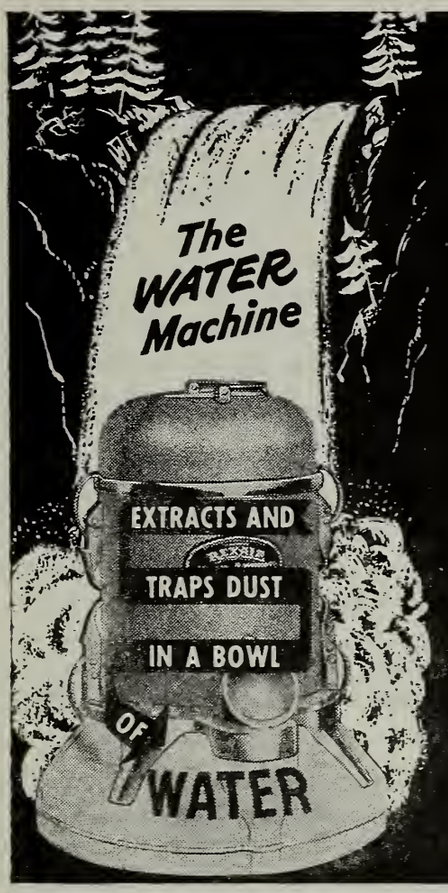
* * *

"Seven hundred and fifty thousand doctors, nurses, and hospital personnel would enter our Government employment, Washington would guide and control it, drying up the voluntary source of skill, mercy, health, and hospitalization. Multiply 750,000 by four and you get another group who will vote according to the promises of appropriations for their particular benefit."—*Hon. Ralph W. Gwinn, Congressman from New York.*

* * *

"We are following in the footsteps of Great Britain. We are much further along the road than we suspect. If we do not clearly recognize that fact and abandon that fatal road, we shall inevitably, perhaps in less than a decade, be in the condition the British now find themselves."—*John T. Flynn's book, The Road Ahead, as condensed in the February, 1950, issue of Reader's Digest.*

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In Memoriam . . .

George Dana Cameron, Sr., M. D., Chagrin Falls; Cleveland University of Medicine and Surgery, 1895; aged 80; died February 15. Dr. Cameron began his practice in Chagrin Falls shortly after completion of his education. He was mayor of the town at one time; and was a 50-year member of the Masons and one of the founders of the local Kiwanis Club. Surviving are his widow; two sons, including Dr. George D. Cameron, Jr., and two brothers.

Chelsea Austin Coleman, M. D., Dayton; Indiana Medical College, School of Medicine of Purdue University, Indianapolis, 1906; aged 65; died February 13 in Hollywood, Fla.; member of the Ohio State Medical Association and the American Medical Association; member of the American Urological Association and the American College of Surgeons. Dr. Coleman practiced his profession in Dayton from 1913 until his retirement about nine years ago. Among survivors is a brother, Dr. Marion Coleman of Dayton.

Sara Davies, M. D., Toledo; Cleveland-Pulte Medical College, 1899; aged 84; died February 10. Dr. Davies began her practice in Toledo in 1905 and continued until a few months ago. Surviving are two sisters.

Ralph Waldo Dawson, M. D., Detroit, Mich.; Starling Medical College, Columbus, 1905; aged 71; died February 28. Dr. Dawson practiced for a short time in East Liverpool before leaving for Detroit in 1919. Surviving are his widow, two sons and a sister.

Reaves Warren DeCrow, M. D., Wilmington; Eclectic Medical College, Cincinnati, 1901; aged 70; died February 10; member of the Ohio State Medical Association and the American Medical Association; secretary-treasurer of the Clinton County Medical Society, 1943-1950; chairman of its legislative committee, 1943-44. Dr. DeCrow had been in public health work since 1920. He was commissioner of Clinton County from 1940 until the time of his death, and formerly served for 12 years as health commissioner of Scioto County. He served for the year 1944-45 as president of the Ohio Federation of Public Health Officials. He was active in several Masonic orders and was a member of the American Legion, being a veteran of World War I. Surviving are his widow, a son and two daughters.

Joseph Deutsch, M. D., Cleveland Heights; Western Reserve University School of Medicine, 1920; aged 58; died March 8; former member of the Ohio State Medical Association and the American Medical Association through 1926. Dr. Deutsch served his entire professional career in the Cleveland Heights area. Surviving are his widow, a son, his mother, two brothers and two sisters.

John Henry Duncan, M. D., Killbuck; Ohio Medical University, Columbus, 1904; aged 72; died March 13 as the result of a traffic accident; former member of the Ohio State Medical Association and the American Medical Association during the years 1934, 1937 and 1945. Dr. Duncan was a native of Killbuck and served all of his professional career in Holmes County. He held memberships in the Methodist Church, the Masonic Lodge and the Odd Fellows Lodge. Surviving are two daughters, a sister and a brother.

John W. Evers, M. D., Flint, Mich.; Rush Medical College, University of Chicago, 1902; aged 73; died February 11. Dr. Evers formerly practiced in Fostoria before moving to Flint about thirty years ago. Surviving are his widow, two children and a sister.

Germanus Elvery Gardner, M. D., Barberton; Starling Medical College, Columbus, 1891; aged 83; died February 28; former member of the Ohio State Medical Association and Fellow of the American Medical Association through 1946. Dr. Gardner practiced his profession in Barberton for 40 years before retiring several years ago and before that practiced for several years in Doylestown. Recently he was honored by the Summit County Medical Society by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. He was a member of the Catholic Church, the Knights of Columbus, the Elks and was an honorary member of the Rotary Club. He made his residence with his son-in-law and daughter, Dr. and Mrs. Joseph J. Weber of Barberton. Also surviving are another daughter, three sisters and two brothers.

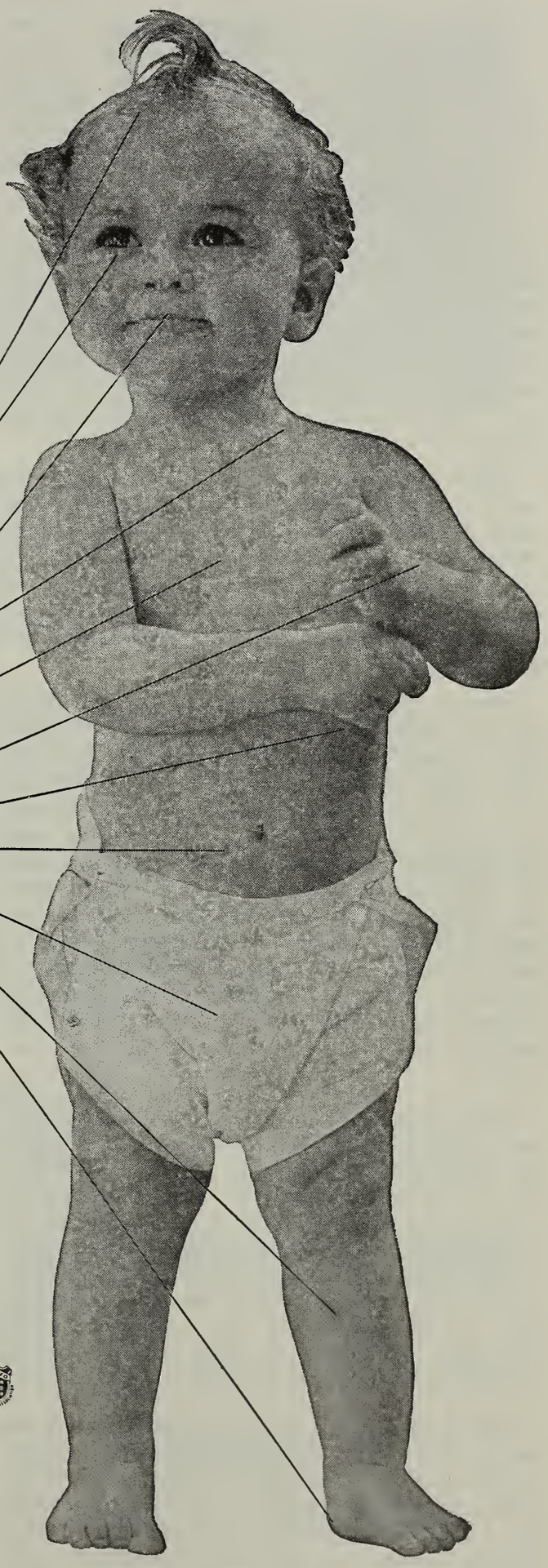
Richard Kittle, M. D., Cleveland; Cleveland Medical College-Homeopathic, 1896; aged 82; died February 18. Dr. Kittle practiced most of his life in the Glenville area. One daughter survives.

Paul Hermann Krebs, M. D., Cleveland; University of Wooster Medical Department, Cleveland, 1894; aged 79; died February 27; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Krebs practiced his profession from the same office for approximately 54 years. Surviving are a brother and a sister.

Morton Morgenstern, M. D., Cleveland; University of Louisville School of Medicine, 1928; aged 46; died February 19; member of the Ohio State Medical Association and a Fellow of the

from *head* to *toe*

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1. "A Study of Enriched Cereal in Child Feeding" Urbach, C.; Mack, P. B., and Stakes, Jr., J: Pediatrics 1:70, 1948.

*Cerevim contains neither vitamin A nor C but possibly exercises an A-and-C sparing effect attributed to its high content of protein and major B vitamins.

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American Medical Association. Dr. Morgenstern had practiced in Cleveland for approximately 19 years. He was a member of Phi Delta Epsilon, Kappa Nu and several Masonic orders. He also was a captain in the Reserve Medical Corps. Surviving are his widow, two daughters, his mother, two sisters and a brother.

Oliver U. O'Neill, M. D., Ironton; University of Louisville School of Medicine, 1897; aged 79; died February 24; member of the Ohio State Medical Association and the American Medical Association; delegate of the Lawrence County Medical Society, 1918, 1927 and 1930. Dr. O'Neill practiced his profession for many years in Ironton and vicinity and for a number of years was city health commissioner. Surviving are his widow, a son and a daughter.

Henry Francis Rohs, M. D., Cincinnati; Creighton University School of Medicine, Omaha, 1929; aged 48; died February 14; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Rohs was chief of staff at Our Lady of Mercy Hospital for a number of years. Surviving are his widow, three sons and two daughters.

Charles Jerome Shepard, M. D., Columbus; Bellevue Hospital Medical College, New York, 1894; aged 79; died March 8; member of the Ohio State Medical Association and a Fellow of the American Medical Association; diplomate of the American Board of Dermatology and Syphilology; member of the American Academy of Dermatology and Syphilology. Since 1940 Dr. Shepard had been professor emeritus in dermatology at Ohio State University College of Medicine where he previously had served for some 40 years. He was a member of the Methodist Church and several Masonic orders. Surviving are his widow, a daughter, a brother and two sisters.

Karl Jacob Simon, M. D., Canton; Western Reserve University School of Medicine, 1932; aged 43; died March 8; member of the Ohio State Medical Association and the American Medical Association; member of the American College of Surgeons. A practicing physician in Canton, Dr. Simon was a veteran of World War II, during which he served in the Army Medical Corps. He was a member of the Catholic Church. Surviving are his widow, three children and his parents.

Harry Streett, M. D., Leroy; Baltimore Medical College, 1894; aged 79; died February 14; member of the Ohio State Medical Association and a Fellow of the American Medical Association; secretary-treasurer of the Medina County Medical Society in 1926, and its president from 1932 through 1934. Dr. Streett began his practice in Litchfield in 1900 and continued there until his retirement about five years ago when he moved to Leroy. He recently was honored by the Medina County Medical Society by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. He was a veteran of the Spanish-American War and was a member of several Masonic orders. Surviving are a son, two brothers and two sisters.

Arthur Dice Traul, M. D., Akron; Starling Medical College, Columbus, 1903; aged 71; died February 27; member of the Ohio State Medical Association and the American Medical Association. Dr. Traul practiced for several years in North Robinson before moving his practice to Akron many years ago. During World War I he served with the Volunteer Medical Service Corps. He was a member of the Methodist Church and several Masonic orders. Surviving are a son, Dr. Donald M. Traul of Cuyahoga Falls, and a sister.

Dwight Addison Weir, M. D., Mansfield; University of Rochester School of Medicine, 1930; aged 46; died February 15; member of the Ohio State Medical Association and a Fellow of the American Medical Association; secretary-treasurer of the Richland County Medical Society, 1934; vice-president, 1935; president, 1936; diplomate of the American Board of Pediatrics; member of the American Academy of Pediatrics. Dr. Weir had practiced his profession in Mansfield since 1933. In addition to his medical work, he was a member of the Rotary Club, the Elks Lodge, the Presbyterian Church and was active in other civic affairs. Surviving are his widow, two daughters, a son, two brothers and a sister.

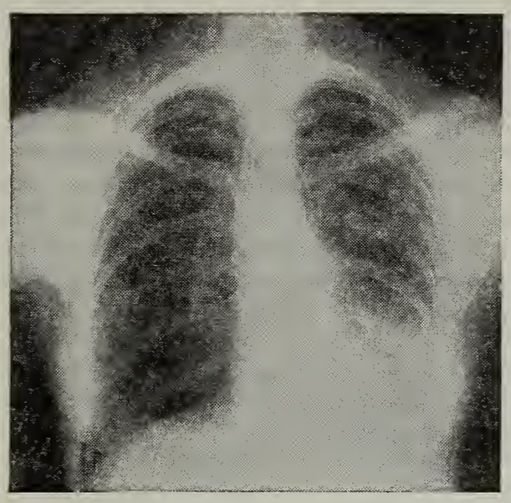
Herman Welland, M. D., Greenville, Va.; College of Physicians and Surgeons of Baltimore, 1899; aged 78; died February 28; former member of the Ohio State Medical Association and the American Medical Association through 1945; president of the Stark County Medical Society in 1933. After 26 years of practice in Canton, Dr. Welland retired from active practice in 1945 and returned to his former home in Virginia. Surviving are his widow, a son and a daughter.

Public Health Association To Meet May 11-12

The annual meeting of the Ohio Public Health Association is scheduled for May 11-12 in Columbus. Theme of the conference will be "Public Health Education in Ohio."

Speakers are being invited to discuss the topics, "Methods of Health Education"; "Health Education in the Newer Fields of Public Health"; and "Professional Staff In-service Training in Public Health."

Section groups are urged to carry this theme of public health education through their group discussions.



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Buckeye News Notes . . .

Ashland—Officers of the medical staff of the Samaritan Hospital are: Dr. E. L. Clem, president; Dr. L. Harold Martin, vice-president; and Dr. Wayne C. Smith, secretary-treasurer.

Ashtabula—Dr. Harold C. Franley of Jefferson was elected a member of the Ashtabula County District Board of Health.

Belleville—Dr. F. J. Heringhaus, Mansfield, addressed the local P.-T. A. on the subject, "Socialized Medicine."

Calcutta—Dr. Robert M. Dunlap, East Liverpool, Columbiana County health commissioner, spoke before the local P.-T. A. on reorganization of public health in the district and the proposed new school health program.

Canton—Dr. E. Scott Hill, upon his return from a trip to England, reported in a public interview the dissatisfaction of British doctors with the health program in that country.

Chardon—Dr. William P. Edmunds, Independence, was named Geauga County health commissioner.

Cleveland—Dr. Irvine H. Page addressed members of the Michigan Heart Association at the annual meeting held in Detroit on the subject of high blood pressure.

Cleveland—Dr. Charles L. Hudson addressed members of the Northeast Property Owners Civic Association on the subject, "Compulsory Health Insurance."

Gallipolis—Dr. Franklin H. Schaefer, New Haven, Conn., has accepted the position as head of the new department of pediatrics at the Holzer Hospital.

Kenton—Dr. John A. Mooney is now in Japan serving as a civilian doctor with the U. S. Army.

Lima—Dr. Calvin L. Baker, Columbus, commissioner of mental hygiene for the Ohio Department of Public Welfare, addressed the Allen County Mental Hygiene Association.

Mansfield—Dr. Harry Wain spoke before the Lincoln Heights P.-T. A. where he explained the work of the Richland County Health Department.

Millersburg—Dr. Harry Duncan addressed the Holmes County Cancer Society at the Pomerene Memorial Hospital.

Piqua—Dr. Harry E. Shilling, Troy, was reelected president of the Miami County Tuberculosis and Health Association.

Westerville—Dr. Harrison S. Evans, Worthington, spoke before the Northern Franklin County Mental Hygiene Association which met at Otterbein College.

Wooster—Dr. John Paul Miller of Orrville was elected to the Wayne County Board of Health for a five-year term.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since February 1, 1950. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

BROWN COUNTY
Charles H. Maly, Sardinia

COLUMBIANA COUNTY
Wade A. Bacon, Lisbon

CRAWFORD COUNTY
Glenn R. Margard, Galion

CUYAHOGA COUNTY
Gilbert I. Anderson Cleveland
Raymond N. Ferreri, Cleveland
Willard T. Hill, Cleveland
Gerhard Hoffman, Cleveland
Shozo Iba, Cleveland
Walter R. Katzenmeyer, Bay Village
Avard C. Long, Cleveland
Norman S. Manica, Cleveland
Robert B. Marshall, Lakewood
William E. Neville, Cleveland
Richard T. F. Schmidt, Cleveland

FRANKLIN COUNTY
Norman E. Goulder, Columbus
John E. Stephens, Columbus

HAMILTON COUNTY
Albert A. Brust, Cincinnati
Noble O. Fowler, Jr., Cincinnati
Charles V. Pfahler, Cincinnati
Lee S. Rosenberg, Cincinnati
Robert E. Shirley, Cincinnati

HIGHLAND COUNTY
Andrew M. Brenner, Hillsboro

JEFFERSON COUNTY
Irving Dreyer, Toronto
Frances J. Shaffer, Toronto

KNOX COUNTY
John F. Robinson, Mt. Vernon

LAKE COUNTY
Richard W. McBurney, Painesville

LOGAN COUNTY
Donald E. Minch, Lakeview

LUCAS COUNTY
Merlin B. Budd, Toledo
Herbert A. Richardson, Toledo
Gregor Sido, Toledo

MEIGS COUNTY
LeGrande Gribble, Pomeroy

MONTGOMERY COUNTY
Edith Gitman, Dayton

SANDUSKY COUNTY
Robert A. Borden, Fremont

SCIOTO COUNTY
Louis R. Chaboudy, Portsmouth

STARK COUNTY
Norman Lewis, Canton
Myrl D. Musgrave, Canton

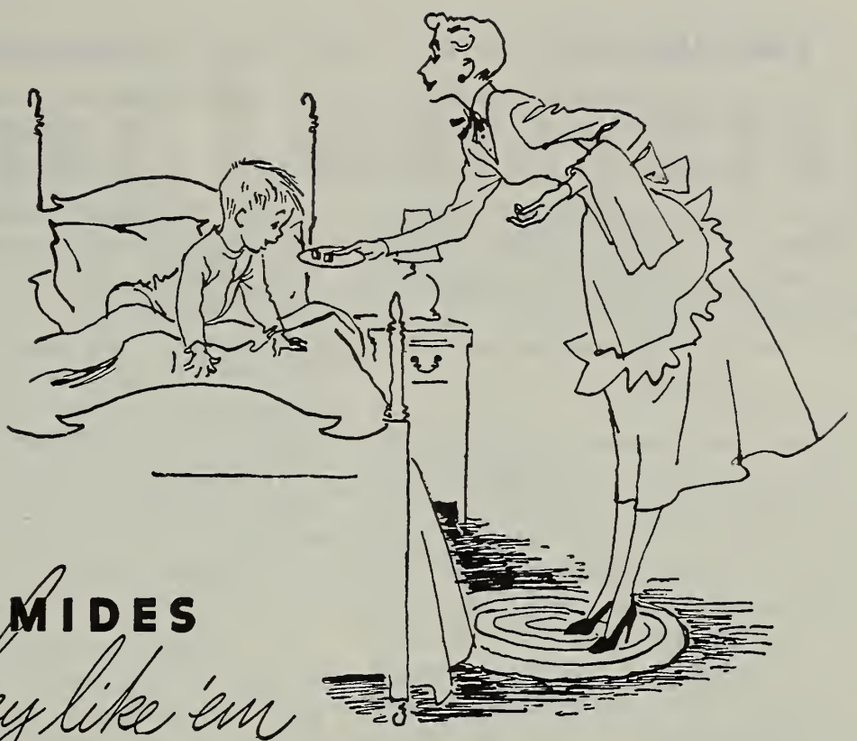
WYANDOT COUNTY
Talmadge R. Huston, Carey
Frederick B. Western, Apple Creek

Hamilton Academy Elects

The annual meeting of the Hamilton Academy of Medicine was held in mid-January at the Hamilton City Club. Officers for the year are: Dr. C. U. Hauser, president; Dr. Edward Keating, president-elect; Dr. G. E. Marr, secretary; Dr. John Borelli and Dr. H. A. Moore, councilors.

Dr. Hauser reported that the group of physicians of the City of Hamilton now beginning its third year numbered 52. Subjects discussed included: Improvement of the practice of medicine in Hamilton; care of indigent especially in respect to legislation; advisability of having a doctor on the Hamilton Safety Council. It was decided to hold monthly educational meetings.

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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

BROWN

Dr. William L. Faul, Georgetown, and Dr. George P. Tyler, Jr., Ripley, were reelected president and secretary-treasurer, respectively, of the Brown County Medical Society. Dr. Faul also is delegate and Dr. Tyler, alternate.

CLINTON

Two physicians were honored by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association through the Clinton County Medical Society. They are Dr. Elizabeth Shrieves and Dr. Frank A. Peelle, both of Wilmington. Since neither doctor was able to be present at the meeting, Dr. David W. Heusinkveld, Cincinnati, Councilor of the First District of the Ohio State Medical Association, passed the pins on for presentation to Dr. R. H. Vance, president of the Society. Dr. Vance later made the presentations at the homes of the 50-Year doctors.

Dr. Richard R. Buchanan, Wilmington, has been elected to succeed the late Dr. R. W. DeCrow as secretary of the Clinton County Medical Society.

In place of the regular March meeting, the Clinton County Medical Society met with the societies of Highland and Fayette counties in a tri-county meeting in Greenfield, March 1. Subject of discussion was "Intestinal Obstructions." Clinton County was represented by the following doctors: Drs. R. H. Vance, Robert Conard, J. H. Frame, Kelley Hale, A. F. Lippert and R. R. Buchanan. Two more tri-county meetings will be held during the remainder of 1950.

HAMILTON

The program of the Academy of Medicine of Cincinnati for April and May includes the following features and speakers:

April 4—"The Psychology of Eating," by Dr. Hilde Bruch, College of Physicians and Surgeons, Columbia University, New York.

April 18—"Factors in the Control of Bleeding," by Walter H. Seegers, Ph. D., Wayne University College of Medicine, Detroit.

May 2—"Management of Menstrual Irregularities," by Dr. William F. Mengert, Southwestern Medical College, Dallas, Texas.

May 16—"Drug Allergy," by Dr. William B. Sherman, College of Physicians and Surgeons, Columbia University.

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CHAMPAIGN

Dr. D. C. Houser was honored at a meeting of the Champaign County Medical Society on Feb. 15, by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. Dr. Houser is a Past-President of the Association. He has not missed an Annual Meeting of the Association since 1898, and for most of those years he has attended as a member of the House of Delegates.

Presentation was made by Dr. Merrill D. Prugh, Dayton, Councilor of the Second District, and Dr. R. D. Dooley, also of Dayton, president of the Second District.

CLARK

Dr. Milton M. Parker, Ohio State University College of Medicine, Columbus, addressed the Feb. 20 meeting of the Clark County Medical Society on the subject "Epilepsy." The meeting was held in the Nurses' Residence of City Hospital, Springfield, where the Woman's Auxiliary afterwards served refreshments.

DARKE

"Recent Advances in Geriatrics" was the topic of a talk by Dr. John Tucker of Cleveland at the Feb. 21 meeting of the Darke County Medical Society in Greenville.

MIAMI

The regular meeting of the Miami County Medical Society was held on March 3 at Memorial Hospital in Piqua. Dr. Allan C. Barnes, chairman of the Department of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus, discussed "The Diagnosis and Management of the Infertile Couple."

The secretary announced that he had obtained 100 copies of the book, *The Road Ahead*, for distribution at 50 cents per copy, in agreement with a resolution passed by the Society.

Upon completion of the Society's present radio program series entitled "The Public Comes First," over Station WPTW on Saturday mornings, two special programs, "Compulsory Health Insurance" and "The Health Insurance of England," will be presented.

PREBLE

Preble County Medical Society officers for the year are: Dr. A. L. Ross, West Alexandria, pres.; and Dr. Birna R. Smith, Lewisburg, secy.-treas. Delegate and alternate, respectively,

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Third District

(COUNCILOR: J. CRAIG BOWMAN, M. D., UPPER SANDUSKY)

HARDIN

Officers of the Hardin County Medical Society for the present year are: Dr. C. L. Johnson, pres.; Dr. Henri A. Kerns, vice-pres.; and Dr. Elizabeth Brungard, secy.-treas.; all of Kenton. Delegate and alternate, respectively, are Dr. F. M. Elliott of Ada and Dr. Johnson.

MERCER

Dr. M. L. Downing, Rockford, recently was honored by being presented the 50-Year Pin and Certificate of the Ohio State Medical Society through the Mercer County Medical Society. Dr. Downing has served 48 of his years of practice in Rockford.

WYANDOT

Members of the Wyandot County Medical Society elected the following officers for the present year: Dr. Franklin M. Smith, Sycamore, pres.; Dr. Henry Vogtsberger, Upper Sandusky, vice-pres.; and Dr. Raymond T. Murphy, Carey, secy.-treas.

Dr. Claude W. Montgomery of Sycamore was honored by the Wyandot County Medical Society by being presented the 50-Year Pin and Certificate of the Oiho State Medical Association. Dr. J. Craig Bowman, Upper Sandusky, Councilor of the Third District of the Ohio State Medical Association, made the presentation.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

HENRY

Dr. J. A. Ruder of McClure was honored on March 2 at a community gathering in which members of the Henry County Medical Society took a leading part. He was presented the 50-Year Pin and Certificate of the Ohio State Medical Association.

LUCAS

The program of the Academy of Medicine of Toledo and Lucas County included the following speakers and features:

General Meeting, Feb. 3—"Intern and Residency Training and Specialization Problems in Medicine Today," Dr. Edwin P. Jordan, Cleveland.

Section on Pathology, Experimental Medicine and Bacteriology, Feb. 10—"Recent Concepts of the Etiology and Pathogenesis of Arteriosclerosis," Dr. Donald C. Wilson, Toledo; and "Hodgkin's Disease Discovered During Breast Surgery," Dr. Fred M. Douglass, Jr., Toledo.

Medical Section, Feb. 17—"Nutritional Problems in Relation to Anastomotic Surgery," Dr. Chester M. Jones, Harvard Medical School, Boston.

Surgical Section, Feb. 24—"Surgery of Patent Ductus Arteriosus," Dr. Willis J. Potts, Children's Memorial Hospital, Chicago.

PUTNAM

Officers of the Putnam County Medical Society are: Dr. M. W. Palestrant, Continental, pres.; Dr. Donald B. Lucas, Columbus Grove, vice-pres.; Dr. Carl J. Heitz, Fort Jennings, Secy.-treas. The delegate is Dr. Wayland B. Recker, Leipsic, and alternate, Dr. Milo B. Rice, Pandora.

Guest speaker at the Feb. 7 meeting of the Society was Dr. Harry E. Tebrock, medical director for the Sylvania Electric factories, New York, who discussed health and accident problems encountered by industrial employees.

WOOD

Dr. Henry Zimmerman, teaching fellow in Medicine at Western Reserve University School of Medicine, spoke to the Wood County Medical Society at the regular dinner meeting at the Midway Restaurant Perrysburg on Feb. 16. His subject was "Newer Aspects of Diagnoses of Congenital Heart Disease."

With the aid of diagrams projected on the screen Dr. Zimmerman was able to present the technique of cardiac catheterization and its indications in a very interesting manner.

The variations in oxygen concentration in the chambers of the heart in the different types of deformity as determined by this method and its refinement at Western Reserve University were described. Dr. Zimmerman spoke briefly also on the surgical treatment as indicated by heart catheterization.

The paper was discussed by Dr. Frank Clifford of Toledo and Dr. Nathan Worth Brown, also of Toledo. The discussants brought out the various practical applications of this new method in routine practice and spoke of its essential harmlessness.

Dr. Zimmerman generously replied to the many questions put by the members who expressed themselves as delighted with the paper. A rising vote was tendered Dr. Zimmerman.

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

LAKE

A movie on "Malnutrition" was shown to the Lake County Medical Society at Lake County Memorial Hospital on Feb. 14, as part of a program for which Dr. Paul E. Reading, presi-

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dent, was chairman. The Society heartily approved of an extension of the Blue Cross plan for hospital insurance to cover more persons in Lake County than are now members.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

TUSCARAWAS

Dr. Elizabeth Rowland-Aplin, Dover, county health commissioner, addressed the January meeting of the Tuscarawas County Medical Society in New Philadelphia on the theme of necessity for prompt report and classification of birth and death certificates. She also discussed control of ringworm infection. Dr. R. J. Foster, New Philadelphia, Councilor of the Seventh District of the Ohio State Medical Association, gave a report on cancer.

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Eighth District

(COUNCILOR: CHESTER P. SWETT, M. D., LANCASTER)

GUERNSEY

Dr. M. C. McCuskey was in charge of the scientific program for the Feb. 2 meeting of the Guernsey County Medical Society. In his talk entitled "Medical Economics" he reviewed the practice of medicine during the past 25 years.

The Society met in regular session for luncheon at the Hotel Berwick in Cambridge on Feb. 16. Dr. W. I. Denny, chairman of the committee on public relations, reported regarding a recent meeting of his committee with the Guernsey County commissioners. It was agreed upon at that meeting that the commissioners would pay physicians for the care of the indigent at the same rates as are now current in Ohio Aid for the Aged fee schedule.

A motion was passed authorizing the secretary to send a letter to the Ohio State Medical Association, advising it that members of the Guernsey Society are dissatisfied with the manner in which fees for medical services in Aid to the Aged cases are handled. Another motion specified that it is the policy of members to deal directly with the patient in cases which are eligible to receive benefits from the Division of Aid for the Aged, except in those cases involving surgery.

The scientific program was in charge of Dr. Henry Wells who introduced his son, Dr. Arthur Wells of Cincinnati, as the speaker of the day. His subject was "Office Proctology." The talk was followed by a period of discussion. Dr. Kenneth J. Frakes, Cambridge, was received into membership.

At the March 2 meeting, Dr. Denny was in

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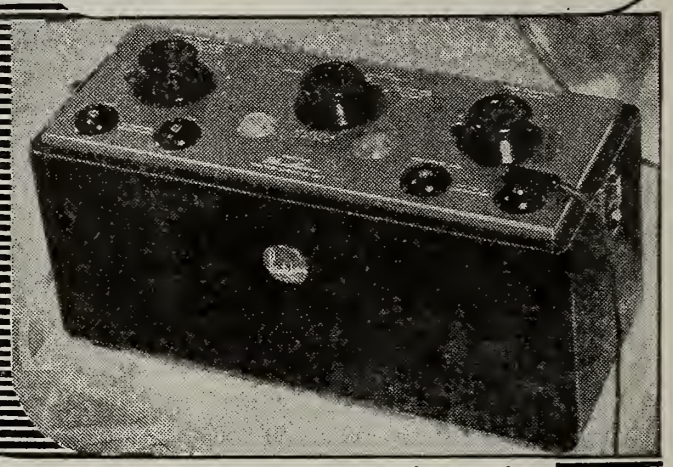
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charge of the scientific program and introduced Dr. James Morton of Zanesville as guest speaker. His topic was "A Study of Sterility."

Further discussion was held on relationship between county commissioners and the profession on the care of indigents. It was announced that the Senior Chamber of Commerce had offered the Society use of its mimeograph and that Miss Helen Rigby, Dr. F. Gordon Lawyer's assistant, had offered to operate the machine when necessary.

Dr. Ben. S. Gillespie announced that he will take graduate work for two years in Cleveland and introduced Dr. William W. Bryant who will take over his practice in Senecaville.

LICKING

Ralph W. Jordan, Columbus, executive vice-president of the Central Hospital Service (Blue Cross), spoke at the Jan. 31 meeting of the Licking County Medical Society at Granville Inn. His subject was "Voluntary Hospital Care."

MUSKINGUM

"Doctors' Legal Duty and Liability for Malpractice" was the topic of a talk by Mr. Richard Schannan, attorney for the Medical Protective Company, at the Feb. 1 meeting of the Muskingum County Academy of Medicine in Zanesville. A business meeting was held on March 1.

WASHINGTON

Five physicians were presented the 50-Year Pin and Certificate of the Ohio State Medical Association at the Feb. 1 meeting of the Washington County Medical Society in Marietta. They are: Dr. E. W. Hill, Sr., Marietta; Dr. Harry W. Hill, Vincent; Dr. I. J. Johnson, Marietta; Dr. J. B. McClure, Marietta; and Dr. Roseberry Rowles, Matamoras. Dr. Chester P. Swett, Lancaster, Councilor of the Eighth District of the Ohio State Medical Association, made the presentations. Wives of doctors were guests at the presentation banquet.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M.D., PORTSMOUTH)

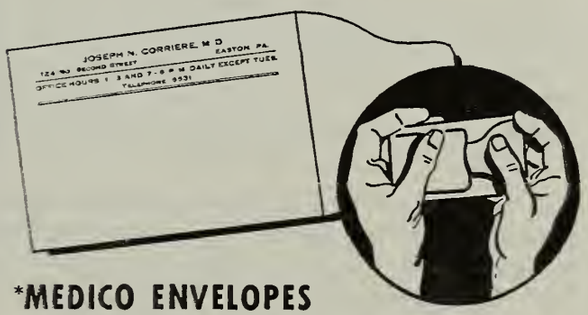
SCIOTO

Two physicians from Ohio State University College of Medicine presented discussions at the Feb. 13 meeting of the Hempstead Academy of Medicine at General Hospital in Portsmouth. Dr. J. J. Jacoby, head of the Department of Anesthesia, University Hospital, spoke on "The Anesthetist in Medical Therapy." Dr. John Garvin, assistant anesthetist, University Hospital, discussed the subject, "Anesthetics for Special Risk Patients." Mr. E. C. Buckner, of Provident Life and Accident Insurance Company, gave a resumé



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Guest speaker for the March 13 meeting of the Academy was Dr. Jack S. Silberstein, Columbus, Ohio State University College of Medicine, whose subject was "The Coronary Artery."

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

DELAWARE

Dr. J. K. James, Delaware, was honored by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association at a joint meeting of the Delaware County Medical Society and the Union County Medical Society at Magnetic Springs in February.

KNOX

Two Knox County physicians were honored by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. They are Dr. James F. Lee of Mount Vernon and Dr. T. L. Eley of Gambier. Dr. I. S. Workman gave a talk on the subject of medical practice in earlier years. The two doctors also were presented gifts from the local society. A delegation of the Society went to the home of Dr. Eley where he was confined because of illness and made the presentation.

MADISON

Following are the officers and representatives elected by the Madison County Medical Society for 1950: Dr. G. C. Scheetz, West Jefferson, pres.; Dr. E. S. Crouch, London, vice-pres.; Dr. William T. Bacon, London, secy.-treas. and delegate; Dr. H. E. Karrer, Plain City, alternate.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

ASHLAND

Officers of the Ashland County Medical Society for the ensuing year are: Dr. G. Deshler Fridine, pres.; Dr. R. J. Ferguson, vice-pres.; and Dr. H. V. Marley, secy.-treas., all of Ashland. Dr. Ferguson is delegate and Dr. M. A. Shilling, also of Ashland, alternate.

LORAIN

Economic, professional and public relations matters pertaining to the practice of medicine were discussed at a business meeting of the Lorain County Medical Society on Feb. 14 at the Pueblo in Lorain.

"Cancer Detection in Rural Private Practice" was discussed by Dr. A. C. Siddall, Oberlin, at

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the March 14 meeting of the Society. The dinner meeting began at 5 o'clock.

The Lorain County Medical Society will present its third annual Postgraduate Symposium on Wednesday, April 26, at the Spring Valley Country Club, Elyria, from 2 to 9 p. m.

The program will be given by a team from the University of Illinois and will consist of the following subjects: "Present Status of Antibiotic Therapy"; "Surgical Therapy of Pancreatic Disease"; "Present Status of Hematological Diseases"; "Jaundice"; "Treatment of Thyrotoxicosis"; and the evening topic, "Clinical Application of Cortisone and ACTH."

MEDINA

Dr. Herbert F. Cowgill, Wadsworth, was elected secretary of the Medina County Society to replace Dr. Morris M. Malmud, Sharon Center, who resigned recently.

ARE YOU AND MEMBERS OF YOUR FAMILY REGISTERED TO VOTE?

Woman's Auxiliary . . .

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AUGLAIZE

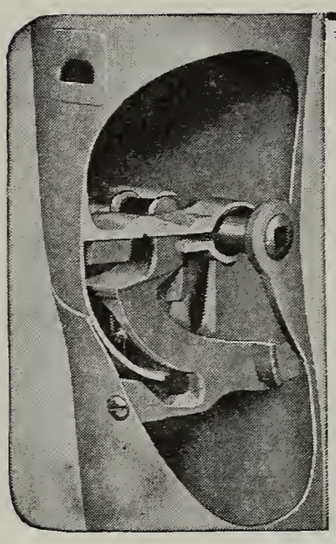
The Woman's Auxiliary to the Auglaize County Medical Society met on Feb. 15 at the home of Mrs. A. W. Veit in Wapakoneta. Mrs. T. H. Will of Minster was welcomed as a new member and also appointed chairman of *To-day's Health* committee. The group received an invitation from the Lima and Allen County Auxiliary to attend its meeting on Feb. 28.

CARROLL

Both the Carroll County Medical Society and its Auxiliary met on March 2 at the home of Dr. and Mrs. S. L. Weir. The Auxiliary reported on its *To-day's Health* subscription drive; the magazine has been placed in all the high schools in the county.

ERIE

"What's New About What's Old" featured the February meeting of the Erie County Auxiliary, when many of its members brought exhibits of their hobbies. The program, which followed the group's regular monthly luncheon, began with Miss Mary McCann's discussion of the books on hobbies to be found in the public library. Miss McCann was introduced by program chairman, Mrs. E. J. Meckstroth. Contributors to an exhibit of rare articles included Mrs. Hugo Sarchet, Mrs. H. L. Sowash, Mrs. C. B. Bliss,



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Mrs. Fred Schoepfle, Mrs. C. E. Swanbeck, Mrs. F. E. Reed, and Mrs. Paul N. Squire.

Mrs. Duane Love was in charge of the Valentine luncheon; she was assisted by Mrs. A. J. Tight and Mrs. R. F. Hoffman.

FAIRFIELD

The Auxiliary to the Fairfield County Medical Society invited their husbands to their meeting on Feb. 16 to hear Dr. Walter T. Secor speak on "France, Crossroads of Europe." Dr. Secor is chairman of the modern language department of Denison University and president of the Ohio chapter of the American Association of Teachers of French.

Following the doctor's talk, lunch was served.

FRANKLIN

Dr. Allan C. Barnes was guest speaker on Feb. 20 when the Auxiliary to the Columbus Academy of Medicine held its annual Guest Day. He spoke on "A Gynecologist's View of Marriage Counseling." This annual guest-day tea was held in the Blue Lounge of Pomerene Hall at Ohio State University. Mrs. Harve M. Clodfelter served as chairman, with Mrs. Joseph L. Ridgeway and Mrs. Dana W. Cox serving as co-chairmen. They were assisted by members of the telephone committee.

GUERNSEY

Mrs. Ben E. Gillespie was hostess on March 2 to the Woman's Auxiliary to the Guernsey County Medical Society when she entertained with a luncheon at Meadowbrook Farms. The luncheon was given as a farewell party by Mrs. Gillespie, as she and Dr. Gillespie are leaving shortly to make their home in Cleveland. A short business session was conducted by Mrs. W. L. Denny. The afternoon was spent socially.

JEFFERSON

Fifty student nurses attended the party given for them in February by the members of the Auxiliary to the Jefferson County Medical Society. Held in the Nurses' Home, the social affair featured games and refreshments. Presiding at the tea table were Mrs. Carl Goehring and Mrs. W. A. Cunningham.

The social and program committees of the auxiliary were in charge of arrangements. Mrs. Albert Sunseri is chairman of the social committee and Mrs. E. B. Weiman is chairman of the program committee.

LICKING

A St. Patrick's Day "theme" provided the atmosphere for the dinner arranged on Feb. 28 in the Moundbuilders Country Club by the Auxiliary to the Licking County Medical Society.

Mrs. G. A. Gressle was appointed chairman

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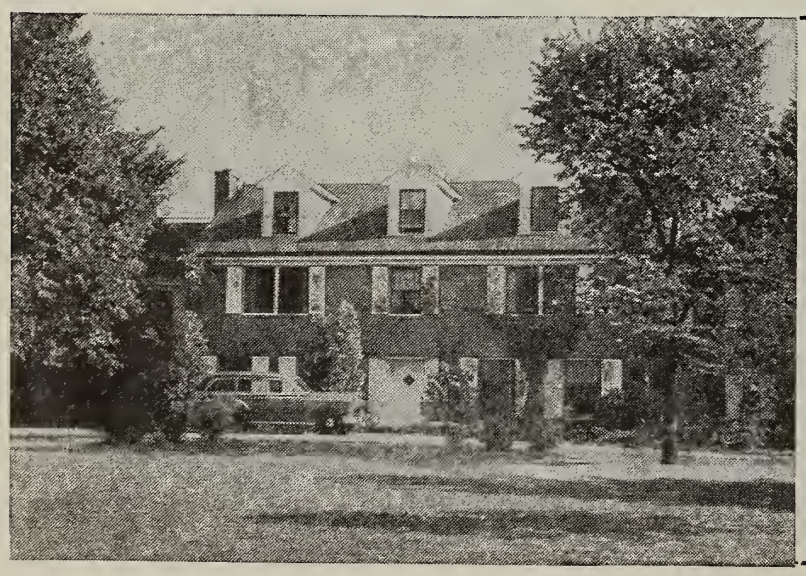
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of the nominating committee; Mrs. Carl Frye, Mrs. Warren Koontz and Mrs. Roland Jones will serve with her. Election of officers will take place at the March meeting. Following the business session, a white elephant auction was held with Mrs. J. Fleek Miller as auctioneer. The proceeds will be used to further nurse recruitment, an Auxiliary project.

LOGAN

The Woman's Auxiliary to the Logan County Medical Society met February 28 in the Blue Room of Hotel Ingalls for a luncheon meeting. Mrs. F. Blair Webster, president, presided and introduced the speaker, Mrs. R. S. Fidler of Columbus, who talked on legislation and answered questions in a general discussion.

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LUCAS

Mrs. C. W. Kirkland, state president, was guest speaker on Feb. 21 at the luncheon meeting of the Woman's Auxiliary to the Toledo and Lucas County Medical Society held in the Woman's Building. A panel discussion on "Our Children" was also held. The participants included: Miss Edna B. Rowe, director of Howe School; Miss Margaret Muller, children's services consultant, and Miss Dorothy Pasch, supervisor of special education of Toledo Public Schools.

A tea honoring Mrs. Kirkland was held the previous day in the home of Mrs. F. W. Clement, president of the Toledo Auxiliary. Guests included Mrs. E. Benjamin Gillette, former state president; Mrs. Wilbur Taylor, former state recording secretary; Mrs. Carll Mundy, state legislative chairman; and Mrs. Eugene A. Ockuly. Members of the board and chairman of committees were also guests.

One of the high points of the social calendar was the supper dance held on February 11 at the Commodore Perry Hotel. Mrs. Ward Meyers was chairman of the dance committee.

The study groups on "Child Development" and "Live Issues of Today" continue to draw high interest.

MARION

The Auxiliary to the Marion County Medical Society held its January luncheon meeting at the Hotel Harding. Preceding the business session, Mr. Robert Mason spoke on "The Problem of Recreation in Marion." The following slate of officers for 1950-51 was presented and accepted:

President, Mrs. J. Greetham; president-elect, Mrs. J. Smyth; vice-president, Mrs. R. L. Gettman; secretary, Mrs. Floyd Yeager; corresponding secretary, Mrs. Merritt Marshall; assistant secretary, Mrs. W. Leffler; treasurer, Mrs. F. G. Smith; assistant treasurer, Mrs. Robert

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GYNECOLOGY—Intensive Course, Two Weeks, starting April 17, June 19. Vaginal Approach to Pelvic Surgery, One Week, starting May 15.
OBSTETRICS—Intensive Course, Two Weeks, starting April 3, June 5.
PEDIATRICS—Intensive Course, Two Weeks, starting April 3. Personal Course in Cerebral Palsy, Two Weeks, starting July 31. Personal Course in Diagnosis & Treatment of Congenital Malformations of the Heart, Two Weeks, starting June 5.
MEDICINE—Intensive General Course, Two Weeks, starting April 24. Electrocardiography & Heart Disease, Two Weeks, starting July 17. Hematology, One Week, starting May 8. Gastroenterology, Two Weeks, starting May 15. Liver & Biliary Diseases, One Week, starting June 5. Gastroscopy, Two Weeks, starting May 15, June 12.
DERMATOLOGY—Formal Course, Two Weeks, starting May 8. Informal Clinical Course every two weeks.
UROLOGY—Intensive Course, Two Weeks, starting April 17. Cystoscopy, Ten Day Practical Course, every two weeks.

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Campbell. It was voted that each auxiliary member will donate to a county school a subscription to *Today's Health*.

A brief business meeting was held on Feb. 18 when the Auxiliary met for its regular monthly meeting. Following the business session, an auction was held, with Mrs. R. L. Morgan serving as auctioneer.

MONTGOMERY

The February meeting of the Auxiliary to the Montgomery County Medical Society was a luncheon meeting at the Biltmore Hotel. About one hundred members were present. Guest speakers were Dr. C. B. Simson, director of the Child Guidance Center, and Dr. J. A. Mendelson, superintendent of the State Hospital. The monthly report on current legislation was presented, following the talks of the guest speakers.

OTTAWA

Reports on a number of interesting events were presented at the February meeting of the Auxiliary to the Ottawa County Medical Society, held at the home of Mrs. George Poe. Mrs. G. A. Boon reported on a rural health conference recently held at Oak Harbor in an effort to consolidate the health program in various points of the county. Mrs. C. R. Wood who attended the northwestern Ohio rural health conference at Bowling Green reported that emphasis is being put on school health programs in an effort to promote a strong realization of health problems. Mrs. W. R. Shortridge told the group that its work in obtaining *Today's Health* subscriptions has shown excellent results. Following the business session, the doctors joined their wives for a social hour.

RICHLAND

Miss Clara Schumm, supervisor of nurses of public health, was the guest speaker on March 6 when the Richland County Auxiliary held its regular monthly meeting. Hostesses for the occasion were Mrs. John Hattery and Mrs. George Evans; the meeting in the form of a luncheon was held at the Women's Club. Spring flowers were used as centerpieces for the small tables.

The speaker gave an interesting and comprehensive talk on "Public Health Nursing" and outlined the history of public health in Richland County and the vastness of its program.

SCIOTO

Dr. L. B. Hatch, president of the Hempstead Academy of Medicine, was guest speaker at the luncheon meeting held at the Turkey Shoppe on March 8 by the Scioto County Auxiliary. Dr. Hatch's talk was on socialized medicine—what has been done, what is being done and what still needs to be done to combat the threat of compulsory health insurance. The business session followed the speaker's address and was con-

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ducted by Mrs. W. A. Ray, president. The nominating committee presented the 1950-51 slate and election of officers was held. The newly elected officers who take office in May include: Mrs. Clyde Everett, president; Mrs. Carter Pitcher, president-elect; Mrs. Carl Braunlin, vice-president; Mrs. Spencer Miller, secretary; Mrs. Ralph Lewis, treasurer; Mrs. Dow Allard, executive board member; Mrs. W. E. Gault, executive board member.

It was voted to designate a recent one hundred dollar contribution of the Academy of Medicine for the Auxiliary's student nurse project. Mrs. G. E. Neff presented her monthly legislative report. Hostesses for the luncheon included: Mrs. W. C. McCann, Mrs. George Blume, Mrs. B. U. Howland, Mrs. A. B. Mills, Mrs. Robert Leever and Mrs. Hubert Thurman.

TRUMBULL

The Trumbull County Auxiliary held a luncheon meeting in February at the Trumbull Country Club. Mrs. D. R. Mathie conducted the business meeting, at which the report was given on the "Gardenia Ball" that was held on Feb. 11 to raise money for the Auxiliary's two-hospital projects. The "Ball" was a big success; the Auxiliary was able to give each hospital approximately $360. It was also voted to give an annual $25 bond to the outstanding student nurse of the year.

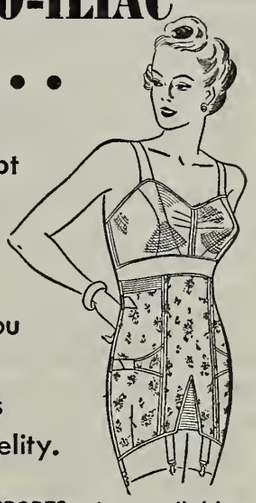
The afternoon's program was an interesting talk by Mrs. Louise Toombs on "Ceramics," presented with effective illustrations. Another speaker was Mr. Biddlestone who described the activities of the Warren Health Department.

Dr. Robert M. Hall of Washington, D. C., has been appointed secretary of the American Medical Association's Council on National Emergency Medical Service, effective January 1, the A. M. A. Board of Trustees announced. Dr. Hall was released from active duty with the Research and Development Board of the U. S. Army December 19.

Fort Steuben Academy

The Fort Steuben Academy of Medicine held its Fifth scientific meeting of the year at the Fort Steuben Hotel on February 14. Dr. James Barrett Brown of St. Louis presented a paper dealing with plastic surgery in general repair of compound injuries of the face. Dr. William L. White, Department of Plastic Surgery of the University of Pittsburgh, opened discussion on the paper.

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Death Rate Reached Low of 9.9 Per 1,000 in 1948

The death rate for the United States in 1948 was the lowest in the history of the country, according to an announcement based on a compilation just completed by the Public Health Service's National Office of Vital Statistics.

The crude death rate for 1948 was 9.9 per 1,000 population—two per cent below the rate of 10.1 for 1947 and one per cent lower than the 1946 rate, the previous record low, the report showed.

The leading causes of death remained the same as in 1947. The major chronic diseases associated with advanced age accounted for 63 of every 100 deaths. Death rates in this group showed only slight changes from the 1947 record. The death rate for diseases of the heart was 322.7 per 100,000 population, while the 1947 rate was 321.2. The death rate for cancer and other malignant tumors increased from 132.4 in 1947 to 134.9 in 1948. The death rate for diabetes remained about the same for the two years; the 1947 rate was 26.2, and the 1948 rate was 26.4. Deaths from nephritis and from intracranial lesions of vascular origin each showed small declines. The 1948 death rate for intracranial lesions was 89.7, while the 1947 rate was 91.4. The nephritis death rate dropped from 56.0 in 1947 to 53.0 in 1948.

Mortality from the major infectious diseases continued their long-time declines. The death rate for pneumonia and influenza, combined, and the rate for tuberculosis both reached new lows. A 10 per cent decline from the 1947 rate brought the death rate for tuberculosis (all forms) for 1948 down to 30.0 per 100,000 population and the rate for pneumonia and influenza down to 38.7.

Motor-vehicle accident deaths decreased for the second successive year. The rate for 1948 for this cause was 22.1 per 100,000 population, while the 1947 rate was 22.8. The death rate for accidents other than motor-vehicle accidents also decreased from the 1947 rate of 46.6 to 45.0 in 1948.

Mortality from two of the communicable diseases of childhood increased sharply from 1947, a low year. The number of deaths from poliomyelitis and acute polioencephalitis increased from 580 deaths in 1947 to 1,895 deaths in 1948, bringing the death rate back up to the 1946 level of 1.3 deaths per 100,000 population.

Public Health Grants

Public Health Service grants of $907,212 to aid laboratory and clinical research in non-Federal institutions were announced. The awards were made by the National Cancer Institute to hospitals and universities.

Included in the grants are the following in Ohio:

Ohio State University College of Medicine—Dr. Abraham Towbin, $3,834, Evaluation of the anterior chamber technique in the assessment of malignancy; Dr. H. G. Schlumberger, $3,200, Neoplasia in fishes and amphibians.

Ohio State University—Dr. M. S. Newman, $8,100, Synthesis of steroid compounds having oxygenated functions in Ring C.; Dr. H. A. Hoster, $1,660, Studies on Hodgkin's disease and related conditions.

University of Cincinnati College of Medicine—Dr. R. W. Vilter, $7,895, The culture of human bone marrow in a synthetic medium.

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A. M. A. Establishes New Microbiologic Lab

The American Medical Association has established a new microbiologic laboratory.

This new laboratory, which is a section of the Division of Therapy and Research, will investigate the biologic, bacteriologic, immunologic and antibiotic properties of various products which are offered to the medical profession and to the public. In addition to drugs, these include foods, cosmetics, germicides, antiseptics, beverages, serums and vaccines. The safety of these products for human use will be determined. Tests and standards will be formulated for those products for which criteria are non-existent or inadequate.

The laboratory will limit its activities to the examination of products of general interest to the medical profession. It cannot perform investigations for commercial firms or for individual physicians.

The laboratory is under the direction of Velma L. Chandler, Ph. D., who was affiliated with the Food and Drug Administration in the Division of Antibiotics from 1943 to 1948. She is co-author of numerous publications on the standardization and efficacy of several antibiotics. Prior to 1943 Dr. Chandler was engaged in clinical laboratory investigations in southern California.

Schering Award

"The Clinical Use of Steroid Hormones in Cancer," will be the subject of the Schering Corporation, Bloomfield, N. J., award for 1950. Students in medical schools in the United States and Canada may enter the competition by preparing manuscripts on the designated subject in the field of endocrinology. Cash awards of $1,000, $500 and $300 are offered.

The United Cerebral Palsy Associations, Inc., has appointed Mrs. J. Howard Brinckerhoff to head its current program of expansion and national affiliation of its member units throughout the United States.



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The Defiance County Medical Society came up with an excellent example of how presentation of the 50-Year Awards can be used to educate the public as to the part the private practice of medicine is playing in our democratic way of life.

In the first place, local leaders of Defiance City and County and a few old friends were invited as guests to a special dinner meeting of the Society at which the presentations were made. The District Councilor, in this case Dr. Carll S. Mundy of Toledo, was invited to make the presentations and got in some good plugs for the medical profession.

Reporters from *Defiance Crescent-News*, upon invitation of Society officers, interviewed each of the four physicians, obtained pictures of them and carried a series of articles, each of which featured one of the doctors.

The Hicksville High School class in journalism, upon suggestion of the Society, selected two students to visit two of the physicians and write human interest articles based on their interviews. This project was promoted to help educate youth in the private practice of medicine.

A Defiance City High School senior, Rita Hewitt, prepared her class talk on the subject, "Why I Prefer the Private System of Medicine." Speaking on the same subject, she was the winner of a contest sponsored by the Rotary Club in which three boys and three girls spoke on subjects of their own choosing. As the girl winner she was scheduled to be guest of the Rotary for two days at a meeting in Cincinnati.

COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Cleveland, May 16-18.

American Medical Association, Annual Session, San Francisco, June 26-30.

American Association of Industrial Physicians and Surgeons, 35th Annual Meeting, Sherman Hotel, Chicago, April 22-29.

American Association for Thoracic Surgery, Denver, Colo., April 15-19.

American College of Physicians, Boston, April 17-21.

American College of Radiology, San Francisco, Calif., June 25.

American Pediatric Society, French Lick, Ind., May 8-10.

National Tuberculosis Association, Washington, D. C., April 25-28.

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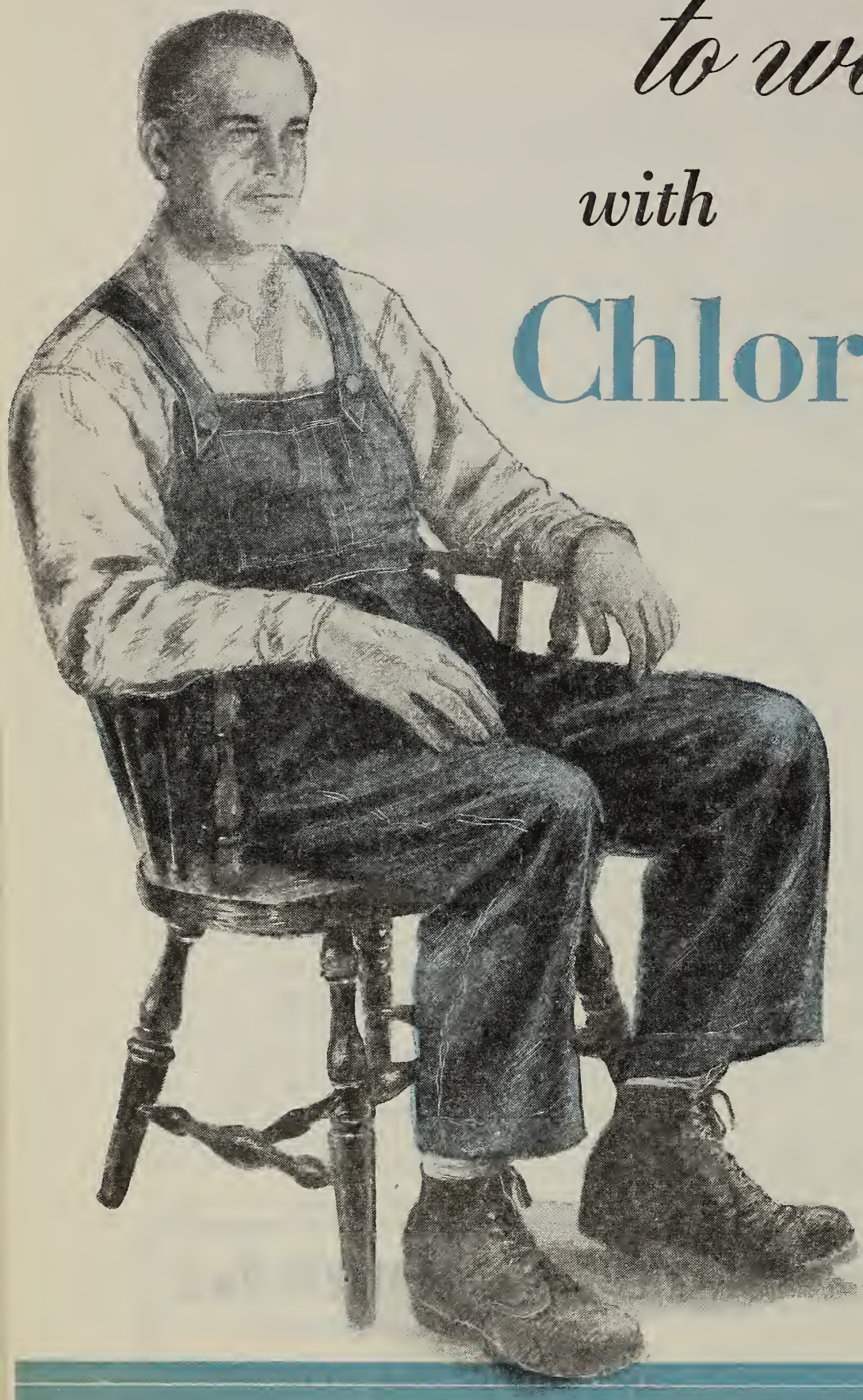
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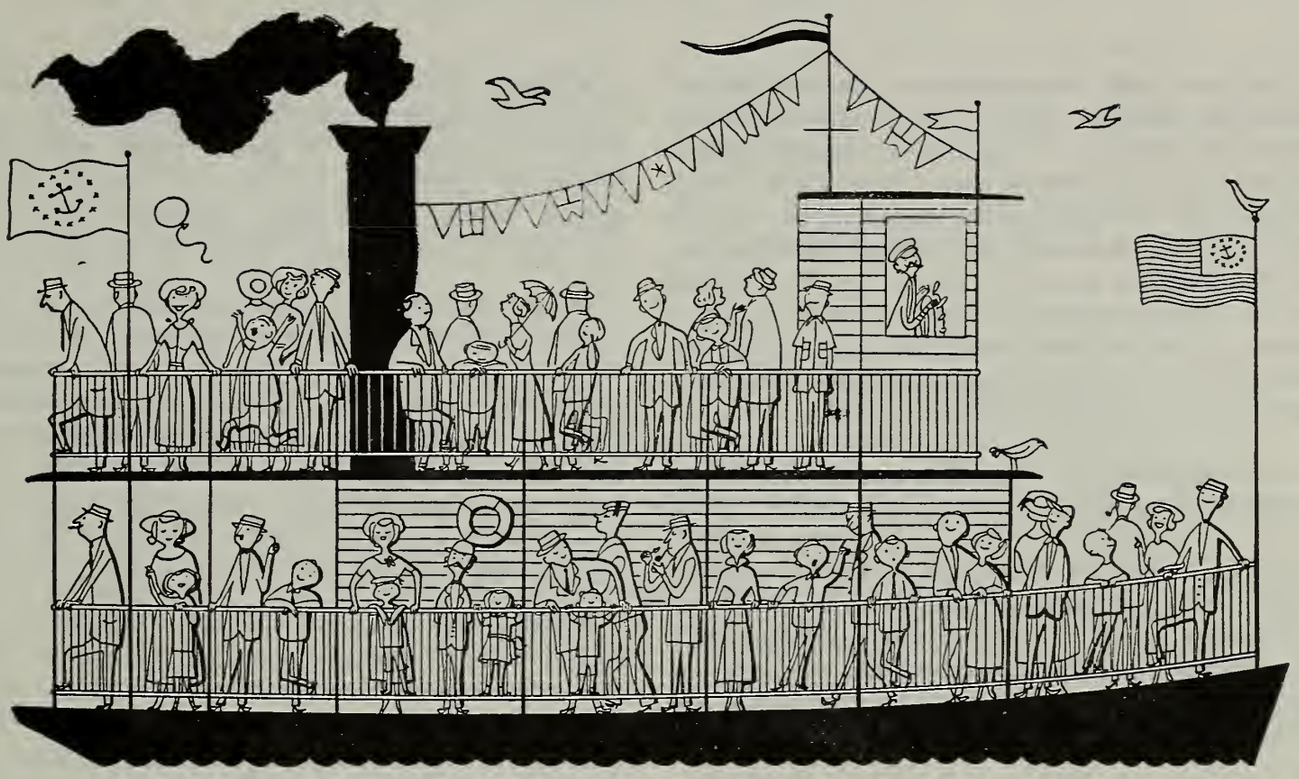




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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Nervous and Neurohumoral Regulations of Intestinal Motility, by W. B. Youmans, Professor of Physiology, University of Oregon ($4.75. *Interscience Publishers, Inc., New York City)*, is one of the publisher's monographs on the Physiological Sciences, and stems from the author's combined interest aroused by W. J. Meek in his demonstration of the role that extrinsic nerves played in the production of death by distension. A complete monograph of interest to all students of the intestinal tract.

Histopathology of the Teeth and Their Surrounding Structures, by Rudolph Kronfeld, M. D., D. D. S., re-edited by Paul E. Boyle, D. M. D. ($8.00. Third Edition. *Lea & Febiger, Philadelphia)*, is designed to illustrate by means of human specimens the actual tissue changes that correspond to certain well-defined clinical observations, i. e., tissue changes following the filling of a cavity, or the filling of a root canal, etc.

Vital Facts of Life, by Rev. Carl H. Harman and E. W. Marquardt, M. D. ($1.75. *Concordia Publishing House, St. Louis, Missouri)*, is a straight-forward discussion of sex and life from the viewpoint of the Lutheran Church. The book also treats with alcoholism, the problem of leisure time, formation of character, success and living one's religion.

Congenital Anomalies of the Heart and Great Vessels—A Clinicopathologic Study of 132 Cases, by Thomas J. Dry, M. D., and five of his associates at the Mayo Clinic ($3.00. *C. C. Thomas, Springfield, Illinois)*. Each case is demonstrated by roentgenography, electrocardiography, diagrams and interior photographs in black and white with the exterior in color. Each is preceded by a title page with a small photograph of the part to be described and a description of the condition from his original report. A truly beautiful work worthy of Rochester, Minnesota.

Electrotherapy and Light Therapy, With Essentials of Hydrotherapy and Mechanotherapy, by Richard Kovacs, M. D. ($10.00. Sixth Edition. *Lea & Febiger, Philadelphia)*, has served for seventeen years as a standard text on Physical Therapy and has been brought up to date to include all that was learned by, and following, World War II.

One Half the People: Doctors and the Crisis of World Health, by Charles M. Wilson ($4.00. *William Sloane Associates, Inc., New York City)*, is a timely discussion of the 1,750,000,000 inhabitants of the world who are sick today. Soon we can expect a population of three billion with two billion or more sick. With this concept as a spring board the author discusses what we can and, in his opinion, should do about it.

Blood and Plasma Transfusions, by M. M. Strumia, M. D., and John J. McGraw, Jr., M. D. ($7.50. *F. A. Davis Company, Philadelphia)*, is an important book for every hospital library. Today it requires a minimum of five blood donors per bed per year. This book brings under the same cover both technical and clinical phases of this remedial agent. There is very little historical and none of the controversial.

Respiratory Enzymes, edited by Henry A. Lardy ($4.50. Second Edition. *Burgess Publishing Company, 426 South Sixth Street, Minneapolis, Minnesota)*, has been written by the staff of the University of Wisconsin. Each of this group of experts has written a chapter on his special interest. The subject, naturally, deals with those enzymes catalyzing the chemical reactions which take place in respiration.

Acute Appendicitis and Its Complications, by Frederick Fitzherbert Boyce, M. D. ($8.75. *Oxford University Press, New York City)*, is the only book of which your reviewer knows that limits itself strictly to this subject. The author rightly insists that we tend to be complacent about the improvement in the statistics of acute appendicitis for 5,153 are said to have died from this disease in 1947. He still puts the emphasis on early diagnosis, prompt operation, and abstinence from purgation.

Meats and Meat Foods, by Lloyd B. Jensen, Ph. D. ($3.75. *The Ronald Press Company, New York City)*, explains in nontechnical language the processes that bring meats and meat products into the consumer's kitchen in sanitary and appetitizing condition. The chief bacteriologists of Swift & Company tell in the volume from the "Humanizing Seven Series" how meat has been made one of the safest, easiest obtained, most nutritious of foods for the American people.

Biochemistry in Relation to Medicine, by C. W. Carter and R. H. S. Thompson ($5.00. *Longmans, Green and Company, New York City)*, discusses for the medical student and those elders who wish to refresh themselves on only those aspects of biochemistry which are at

present significant in medicine. The section on chemical pathology will be of particular interest to most of us.

Introduction to Psychosomatic Medicine, by C. Alberto Sequin, M. D., with foreword by Flanders Dunbar ($5.00. *International Universities Press, New York City)*, helps a good deal to resolve the obstacles that most of us have in looking into the approach through use of clear understandable writing. If we get more discussions on this plane, it may just happen that the dual approach of psychosomatic considerations of the individual's interest may become the dominant one. Certainly, this can never happen if our profession becomes nationalized and each citizen becomes a medical number; for as Dunbar says in the introduction "it is not often that we can apply the same methods to the engineer as to the engine."

Clinical Allergy, by Louis Tuft, M. D. ($12.00. Second Edition. *Lea & Febiger, Philadelphia)*, adds to the splendid first edition what we have discussed and learned in the past ten years. It is a book primarily for the inquiring physician who works in other fields but who realizes that allergy is a large component in the lives of ten per cent or more of the people whom he sees. The enlarged material on Fungi as allergens and a whole new chapter on inhalant allergens other than pollens are noteworthy.

A Review of Nursing, by Helen F. Hansen, R. N., M. A. ($4.25. Sixth Edition. *W. B. Saunders Company, Philadelphia)*, is the modern version of this well-known guide and teaching device with its outlines, its notes, its questions and answers.

Body and Mature Behaviour, by M. Feldenkrais ($3.75. *International Universities Press, Inc., New York City)*, is a study of anxiety, sex, gravitation and learning. It is the reworked series of lectures given before the Association of Scientific Workers at Fairlie, Scotland. Since the author goes carefully into the mechanism underlying the various mental and spiritual cures, it is a book that will prove to be most helpful to many of us. "While expecting hopefully that the environment will be changed by our collective efforts, we must also make sure that everything amenable to human influence in each individual is used to facilitate adaptation."

Physiology in Diseases of the Heart and Lungs, by Mark D. Altschule, M. D. ($5.00. *Harvard University Press, Cambridge, Massachusetts)*, written at the request of third and fourth year medical students. It is designed to be helpful in the correlation of clinical medicine with basic physiology. Many of us older men also may wish to rework our experiences in the light of the new knowledge.

Soil Fertility and Sewage, by J. P. J. van Vuren (18s net. *Faber & Faber, Ltd., 24 Russell Square, London, England)*, is primarily an account of pioneer work in this connection in South Africa. Lady Howard has written the foreword so that the work is slanted toward the "organic school of soil fertility." The squandering of a great inheritance; Nature's revolt against man's abuses; the havoc of ever-spreading soil erosion; the threat of mass starvation; the irresistible logic of the law of return, make action long overdue. Citizens of many cities in this country are studying this problem.

Cancer, by Beka Doherty ($3.00. *Random House, New York City)*, is a popular presentation of our current knowledge and hopes about cancer. It tells about research, clinical research, and the hospital cancer centers and diagnostic services that are now available.

Conflict in Marriage, by Edmund Bergler, M. D., ($2.75. *Harper & Brothers, New York City)*, is the story of the unhappy undivorced by the author of "Divorce Won't Help," "Psychic Impotence in Men," "The Basic Neurosis," and other similar books. This book was written in answer to the charge that the author has been defending marriage on any basis. It explains how one can live in relative peace with one's untreated neurosis. No substitute has ever been found for the emotions as a basis for marriage.

More About Psychiatry, by Carl Binger, M. D. ($4.00. *University of Chicago Press, Chicago, Illinois)*, is 14 chapters—majority of which have appeared in magazines—by the man who made the front pages in connection with the Alger Hiss trial. In spite of that, those who wish to follow modern medical philosophy will enjoy this little volume. Your reviewer was especially delighted with the essay on "What Can We Learn from a Medical History?"

Urological Aspects of Spinal Cord Injuries, by George C. Prather, M. D. ($3.75. *Charles C. Thomas, Publisher, Springfield, Illinois)*, attacks the problem with a full realization that the restoration of the tract to the best physiological condition, free of major disease, is the most important single step in the management of these patients.

Clinical Pathology—Application and Interpretation, by Benjamin B. Wells, M. D. ($6.00. *W. B. Saunders Company, Philadelphia)*, brings out the worthwhile things in the diseases of the various anatomic system. A good book to sort out the most important things from the great maize of detail in the larger books.

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The Ohio State Medical Journal

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JONATHAN FORMAN, M. D., *Editor*

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Asst. Managing Editor

Present Concepts in the Diagnosis and Treatment of Acute Pancreatitis

VINTON E. SILER, M. D., and JOHN H. WULSIN, M. D.

THE clinical management of acute pancreatitis poses a problem that is an integral part of the larger problem of abdominal surgery. Because of the intimate association of the pancreas with neighboring organs, inflammatory disease of the pancreas frequently disturbs the proper functioning of surrounding structures. The clinical diagnosis of pancreatitis is not always easily made, and pancreatic inflammation is often mistaken for other clinical entities of the upper abdomen. A review of the literature[1] reveals that much scientific factual knowledge concerning pancreatitis is lacking and that there is dispute about many phases of the disease. The present concept of the physiology and pathology of the pancreas do not allow physicians in general and surgeons in particular to approach with diagnostic certainty the treatment of inflammatory diseases of this organ. The purpose of this presentation is to discuss some of the problems involved in the understanding and treatment of pancreatitis.

The Authors

● **Dr. Siler, Cincinnati, Ohio, is a graduate of University of Cincinnati College of Medicine, 1934; diplomate, American Board of Surgery; fellow, American College of Surgeons; attending surgeon, Children's, Holmes, Jewish, Bethesda, and Cincinnati General Hospitals; and asst. prof. of surgery, College of Medicine, University of Cincinnati.**

● **Dr. Wulsin, Cincinnati, Ohio, is a graduate of University of Rochester School of Medicine and Dentistry, 1944; and asst. resident in surgery, Cincinnati General Hospital.**

ETIOLOGY OF ACUTE PANCREATITIS

Although the cause of pancreatitis either in its acute or chronic form is not known, numerous attempts have been made to solve the mystery of its etiology both in the laboratory and at the bedside, but non-partisan observers, even today, generally agree that a wholly satisfactory answer has not yet been given. Difficulty in obtaining that answer may well rest in the fact that workers are individually talking about different phases of pancreatitis without so realizing. Each hypothesis may be true for a small segment of facts that it covers without actually contradicting other theories, which also are only valid for other segments of facts. If observers, instead of offering a comprehensive explanation of pancreatitis, would restrict their conclusions to the evidence they have accumulated, we might one day find that the assorted theories, when pieced together into a larger picture, would, like the united parts of a jigsaw puzzle, create a clear intelligible whole.

In this light each of the theories and assorted facts bears equal importance until more is known, and while a brief summary may seem confusing and inconclusive, it will emphasize that no one theory in its present stage is adequate to account for all facts.

A number of more or less complete reviews

Presented before the Section on Surgery at the Annual Meeting of the Ohio State Medical Association, Columbus, Ohio, April 19, 1949.

of the literature bearing on etiology are available in English. Dragstedt, Haymond, and Ellis[2] (1934), Rich and Duff[3] (1936), Jones[4] (1943), Rienhoff and Pickrell[5] (1945) note most of the important ideas and references. The discussion that follows does not pretend to be all-inclusive. It will attempt to indicate the significant points and select work illustrating those points, without cataloguing the vast amount of experimental and clinical papers on this subject. Since our ultimate ignorance precludes an accurate description of the early stages of the pathogenesis of this disease, various authors usually tailor a theoretical explanation of pathogenesis to fit the particular etiological concept in question. Therefore, in treating the origin of pancreatitis we shall not draw a sharp line between etiology and pathogenesis, and we shall call on any facts that may help to substantiate or clarify the theory at hand. A brief summary of the theories discussed are as follows.

I. Bile flows into the pancreatic duct because an obstruction at the ampulla of Vater creates a common channel between the common bile and the duct of Wirsung.

The experimental injection of bile into the pancreatic duct usually produces acute pancreatitis. The high incidence of cholelithiasis in acute pancreatitis favors the supposition that a gallstone, impacted in the ampulla, blocks the passage of bile into the duodenum and diverts the bile into the duct of Wirsung, but necropsies on cases of acute pancreatitis only occasionally disclose an impacted stone in the ampulla. Spasm of the sphincter of Oddi can without question be associated with the reflux of fluid from the common duct into the duct of Wirsung, as proved by cholangiography. The relation of sphincter spasm to pancreatitis has not been well defined. It is undecided whether the presence of bile in the pancreatic ducts at physiological pressures is harmful or innocuous. In the majority of postmortem specimens, the terminal orifices of the common bile duct and the duct of Wirsung enter the ampulla of Vater in such a manner that reflux of fluid from one duct to the other is possible when the outlet of the ampulla is obstructed. Variations from the normal anatomical structure may prevent communication between the pancreatic and biliary ducts.

II. Obstruction of the pancreatic ducts and autodigestion of the pancreas.

Experimental obstruction of the pancreatic ducts produces fat necrosis and acute edema of the pancreas with subsequent parenchymal atrophy and fibrosis, but acute pancreatitis with hemorrhage and necrosis rarely develops, even though the gland is actively secreting at the time of obstruction. Rich and Duff claim that obstruction to the outflow of pancreatic juice by gross lesions, such as tumor and stone, or by the microscopic lesion, metaplasia of the epithelium in the small ducts, ruptures the duct system and allows pancreatic secretion to escape into the parenchyma, where trypsin becomes active and initiates necrosis. The concept of autodigestion of the pancreas assumes that trypsin is activated within the gland. A mechanism for the activation of trypsin in acute pancreatitis has not as yet been clearly demonstrated. Acute obstruction of the pancreatic ducts is followed by a rise in serum amylase, even though acute pancreatitis with hemorrhage and necrosis does not develop.

III. Infection.

Experimentally the injection of bacteria into the pancreas does not produce acute pancreatitis. Chronic inflammation of the extrahepatic biliary tract commonly accompanies pancreatitis, but specific bacteria are not regularly found in clinical cases of acute pancreatitis. Experimental acute cholecystitis in cats does not cause acute pancreatitis with necrosis. The presence of suppuration in the pancreas implies a bacterial infection, either primary or secondary.

IV. Vascular Factors.

Because of the rich blood supply of the pancreas, experimental infarction is not easily produced. The experimental production of embolus or thrombosis in the pancreatic vessels does not cause a spreading hemorrhagic necrosis, similar to that in acute pancreatitis. It has been suggested that vasoconstriction in the pancreatic vessels may initiate ischemic necrosis. Necropsy studies of acute pancreatitis have failed to reveal a consistent primary lesion of the pancreatic blood vessels.

V. Trauma.

Acute pancreatitis occasionally follows mechanical injury to the pancreas from contusions and perforating wounds of the upper abdomen or from surgical procedures on or near the organ. After pancreatic injury the serum amylase frequently rises although acute pancreatitis does not develop clinically.

VI. Miscellaneous.

a) **Reflux of duodenal contents into the pancreatic ducts.** The passage of duodenal contents into the pancreatic ducts may occur on rare occasions, but it is infrequently associated with acute pancreatitis.

b) **Alcohol.** Clinical observations indicate that alcoholism is frequently associated with acute pancreatitis. An experimental explanation of this association is lacking.

c) **Anaphylaxis.** The concept of an ana-

phylactic origin of acute pancreatitis is for the most part still theoretical.

CLINICAL FEATURES OF ACUTE PANCREATITIS

According to Fitz[6] (1889) Clässen (1842) was the first to establish the clinical entity of acute pancreatitis. Fitz in his own study differentiated three types of the disease: hemorrhagic, gangrenous, and suppurative. More recent observations, particularly those of Zoepffel[7] (1922) and Elman[5, 8] (1933, 1942), have emphasized a milder form of acute pancreatitis, acute edematous or acute interstitial pancreatitis.

Acute pancreatitis as a clinical entity includes all the pathological varieties of acute pancreatic inflammation. It may be subdivided into three categories. (1) Acute edematous (interstitial) pancreatitis refers to the benign form in which the chief pancreatic lesion is edema. (2) Acute pancreatic necrosis and acute hemorrhagic pancreatitis are generally used interchangeably to denote pancreatitis characterized by hemorrhage and necrosis. (3) Acute suppurative pancreatitis implies the presence of purulent exudate within the pancreas. Since the various pathological subdivisions of acute pancreatitis cannot be distinguished clinically at the onset of the disease, physicians are justified in retaining the general term acute pancreatitis until the subsequent course of the disease clarifies its pathological nature. Wherever possible, the specific terminology should be used.

SYMPTOMS

Clinically, acute pancreatitis begins in the upper abdomen with a relatively sudden pain which arises in the mid-epigastrium, occasionally in the right upper quadrant, and radiates to the back or to the left flank. When it originates in the region of the gallbladder, the pain primarily suggests cholecystitis and may mislead the physician, but if it spreads to the left lumbar area and to the left flank, this symptom points to pancreatitis and, in particular, to irritation within the lesser peritoneal cavity. Less commonly it radiates transversely in the epigastrium or becomes generalized in distribution. Pain is the most prominent single symptom of the disease and only rarely is absent. The severity of pain is a rough index of the degree of pancreatic damage. In mild cases of edema the pain may be no more than slight epigastric distress, and as the pathological lesion progresses, the pain increases until it attains excruciating proportions in the event of marked edema or necrosis of the gland. Characteristically, the pain is steady, unrelenting, and uninfluenced by vomiting. Even morphine, which eases the pangs of biliary colic, affords only slight relief.

Nausea and vomiting promptly follow the pain. Although in the mildest instances only nausea is noted, usually vomiting of a reflex nature is conspicuous and persistent. Continuous gagging, retching, or vomiting of bile despite an empty stomach dehydrate and exhaust the patient.

Fever is mild or absent, and chills do not occur. Much emphasis has in the past been placed on the dramatic development of shock as an indication of acute pancreatitis. In those occasional instances when shock is found within the first twenty-four hours of the disease, the pancreas is always severely damaged by massive hemorrhage or necrosis, and death may follow promptly. The large majority of patients do not lapse into shock unless dehydration and uncontrolled pain cause a fall in blood pressure several days after the onset of the disease.

PHYSICAL FINDINGS

In contrast to the alarming nature of the symptoms the physical examination reveals few abnormalities. The patient is rarely in shock, although he often exhibits an anxious weariness, common with any severe abdominal pain. When present, shock is usually severe, and the patient appears moribund. A peculiar ashy cyanosis of the extremities and face with pallor about the lips, marked hypotension, a rapid, weak pulse, and semi-coma may be observed but are not diagnostic of acute pancreatitis in the absence of further information. Patients in this condition rarely survive more than a few hours, and unless the serum amylase is determined the diagnosis is made only at necropsy. On the other hand, subclinical shock, suggested by thirst, pallor, and restlessness, is present in most of the moderately severe cases. Although the blood pressure remains near normal limits and the pulse does not become exceedingly fast, impending collapse can be detected by signs of dehydration. Sudden shock early in the disease generally signifies massive hemorrhage from the pancreas into the abdomen or retroperitoneal tissues. The gradual appearance of shock after a day or two of illness can probably be explained in two ways. The more obvious cause consists in a depletion of blood volume by bleeding from the pancreas, by persistent vomiting, and by the development of large collections of fluid exudate in the greater and lesser peritoneal cavities. The total of fluid by these various routes may amount to several or more liters in the course of even one day. In addition to a depletion of blood volume, shock may result in an ill-defined manner from toxic products which are liberated by the damaged pancreas, especially in instances of marked necrosis.

In the moderately ill patient the temperature is normal or only mildly elevated, while the pulse is increased to about 100. With impending or actual shock the temperature falls to between 35° to 36.5° centigrade. Significant physical

findings, if available, center about the upper abdomen. Spasm of the abdominal muscles is not as a rule present in mild cases, a helpful negative finding, although voluntary guarding in the epigastrium commonly occurs. In the early typical case peristalsis is normal or slightly hypoactive to auscultation and the abdomen is not distended with fluid or gas. Diarrheal stools occurring at this point of the illness indicate a reflex irritation of the colon prior to the onset of paralytic ileus. In a general way, therefore, the over-all absence of striking abdominal findings distinguishes acute pancreatitis in its earlier stages from other upper abdominal emergencies.

After the first day or two of a moderately severe illness, or promptly in extreme cases, examination of the abdomen reveals signs of greater significance. The irritation which arises from a serious pancreatic lesion, whether edematous, necrotic, or suppurative, produces both a reflex paralysis of the bowel and a chemical peritonitis. A general peritoneal effusion, colored a typical "prune juice" shade by hemolyzed blood, produces diffuse abdominal tenderness and shifting dullness in the flanks. Clotted blood does not move about in the peritoneal cavity, and, when collected in the lumbar gutter, may cause only an increased dullness and tenderness in the flank. An effusion within the lesser peritoneal cavity is almost impossible to detect in its early stages by physical examination, but operative and postmortem examinations have established that it occurs with great frequency in acute pancreatitis.

Much clinical emphasis has been placed on the appearance of ecchymosis about the umbilicus (Cullen's sign) or in the flanks, particularly on the left (Turner's sign), since these discolorations are almost pathognomonic of acute pancreatitis. Cullen's sign may, however, as originally described, accompany a ruptured tubal pregnancy. Both of these signs in pancreatitis depend on the extravasation of blood into the retroperitoneal tissues from a marked hemorrhage in the pancreas. The blood dissects forward to the flanks and may proceed to the umbilicus where it collects because of a peculiar arrangement of the fascia. These signs are rarely observed and, if present, indicate severe hemorrhagic pancreatitis. Their usefulness in establishing a diagnosis is further diminished by their relatively late appearance in the illness, generally from the third to the tenth day.

Patients with acute pancreatitis often present some misleading symptoms and signs which may result from secondary effects of the primary disease but which in other instances cannot be logically explained. These are: (1) Gastrointestinal hemorrhage, in the form of bloody vomitus or bloody diarrhea, may be seen in severe instances of pancreatic hemorrhage and necrosis. (2) Jaundice in the absence of gallstones has occasionally been reported in acute pancreatitis, but not nearly as frequently as in chronic pancreatitis. (3) The presence of hypertension in patients with acute pancreatitis has recently been stressed by Paxton and Payne,[10] who observed elevated blood pressures in 20 per cent of 307 cases.

LABORATORY FEATURES

The results of laboratory tests in a case of acute pancreatitis may be divided into findings which are specific and those which are characteristic. A brief discussion of the routine tests will precede the description of the more diagnostic features.

In the early stages of the illness, when dehydration is common, the blood reveals a normal or high number of red cells associated with normal or elevated values of hemoglobin and hematocrit. Once dehydration has been corrected, mild anemia may appear, and a low red cell count indicates extensive hemorrhage from the pancreas. By following the level of red blood cells the physician is aided in deciding when to use blood transfusions and what the prognosis may be. Moderate leukocytosis (10,000 to 15,000) usually is found. Necrosis may elevate the white blood cell count to 25,000. If the level of leukocytes in the course of acute pancreatitis suddenly rises, the onset of suppuration in the gland must be suspected. The urine is usually concentrated, reflecting dehydration, and in moderately severe cases albuminuria is common, accompanied at times by granular casts and an occasional red cell. Glycosuria is also frequent.

The aid of the clinical laboratory is necessary to make a positive diagnosis of acute pancreatitis. It must be emphatically stated that no laboratory tests are available at the present time which will unequivocally make this diagnosis. The various clinical laboratory features of acute pancreatitis are: (1) Elevated blood amylase; (2) elevated urinary amylase; (3) elevated blood sugar and sugar in the urine; (4) low blood calcium; (5) roentgenologic findings; (6) electrocardiographic changes.

COURSE AND COMPLICATIONS

Acute pancreatitis in its early stages cannot be clinically differentiated into pathologic types as previously stated, but as the disease progresses, certain features appear which tend to identify the particular form.

(1) Acute edematous (interstitial) pancreatitis is present in two-thirds to three-quarters, and perhaps more, of all cases with acute pancreatitis. In mild instances of edematous pancreatitis recovery usually begins two to three days after the onset of the illness. Pain disappears; appetite returns; and soreness gradually leaves the epigastrium. Within a week or less the

patient is ready to resume a normal life. Even in a moderately severe case the course rarely lasts more than two weeks. In many instances the acute edematous variety tends to recur over a period of many years. A patient with acute edematous pancreatitis illustrating its tendency to recur is demonstrated in the following case history.

CASE REPORT

Case 1. H. B. (C. G. H. #156545). This 18-year-old colored female was admitted to the surgical service of the Cincinnati General Hospital on June 18, 1944, with complaint of upper abdominal pain, nausea, and vomiting. She had been a patient on the obstetrical service in April, 1944, when she had delivered spontaneously a full term infant. During the puerperium, complicated by mild fever, she noted for the first time some mild indigestion, which continued in intermittent fashion until a month before admission, when she experienced a sudden attack of severe dull epigastric pain radiating around below the right breast to the right mid-axillary line. The pain persisted for several days, increasing after meals but not accompanied by nausea or vomiting. Bowel movements were regular and normal. The patient claimed that fatty foods tended to cause epigastric discomfort. Alkaline medication by mouth afforded moderate relief. During the month preceding admission she experienced many less severe episodes of epigastric pain. On June 8, 1944, she was seen as an outpatient in the medical clinic, where epigastric tenderness and a large tender liver were noted.

An oral cholecystogram on June 15, 1944, revealed a poorly visualized gallbladder without evidence of stones. Following ingestion of the dye for gallbladder visualization the patient noted that the mild epigastric pain became more severe, especially in the right upper quadrant, and radiated around both costal margins to the back and to the angle of the right scapula. Anorexia, nausea, and vomiting accompanied the pain.

On admission, June 18, 1944, the patient was running a high fever, 104° F, with pulse 100, respirations 20, and blood pressure 120/80. She was obese, toxic, and complaining of pain in the right upper quadrant. The breasts were lactating. The abdomen was not distended. Diffuse tenderness was evident, most marked in the right upper quadrant with spasm in that area. The liver, palpable two finger breaths below the costal margin was tender. The initial laboratory findings included hemoglobin 9.5 gm.; white blood cells 14,900; urine, no albumin, no sugar, three plus bile. The admission diagnosis favored acute hepatitis over a possible cholecystitis.

The patient was treated conservatively and observed. Her temperature dropped to normal in four days. Oral intake was withheld, and intravenous fluids were administered for several days until the abdominal pain, nausea, disappeared. Jaundice, although not apparent clinically, was revealed by an icterus index of 20 on June 19, 1944, the second hospital day, but two days later the icterus index was 9. A serum amylase of 1049 units, drawn on the second hospital day, indicated that there was acute pancreatitis. Subsequent determinations included 462 on June 21, 1944, 304 on June 22, 1944, 187 on June 27, 1944. Roentgenological studies of the upper gastrointestinal tract revealed chronic gastritis without evidence of peptic ulcer. A gastric analysis after histamine found no free HCL. Following recovery from her acute attack the patient submitted to an elective cholecystectomy on July 15, 1944. The head of the pancreas was considered normal by the surgeon, and no fat necrosis was seen. No sign of a peptic ulcer was present. The gallbladder was thickened but contained no stones. The common duct was not enlarged and contained no palpable stones. The gallbladder was removed and the area drained, the postoperative course was benign for the first nine days. Transient mild jaundice was observed, but on the third postoperative day the serum amylase was normal, 123 units. On July 24, 1944, the ninth postoperative day, a sudden attack of epigastric and right upper quadrant pain accompanied by an elevated temperature, pulse, and serum amylase (822 on July 28, 1944) indicated a recurrent bout of acute pancreatitis. The pain was boring, intense and uninfluenced by atropine. The attack subsided spontaneously in several days, and the patient was discharged on August 7, 1944, twenty days after cholecystectomy.

The patient was followed closely in the outpatient department. She continued to have attacks of epigastric pain which radiated straight through to the back, but no longer radiated around the costal margins. Oral hydrochloric acid gave more relief than pancreatin, while nitrites had no effect on the pain. The attacks gradually became milder and finally disappeared about nine months after cholecystectomy. She has been seen at regular intervals up until May, 1948, and has been completely free of indigestion.

* * *

(2) Acute pancreatic necrosis or acute hemorrhagic pancreatitis is found in one-third to less than one-quarter of cases with acute pancreatitis. In fatal cases death usually occurs before the fourth day, but at times it may be postponed for two or three weeks until precipitated by secondary infection or pneumonia. Collections of inflammatory fluid and secretion within the pancreas (pseudocyst) frequently result three to four weeks following the attacks of pancreatic necrosis, and occasionally earlier. When bacteria become established in the inflammatory masses, the organisms evoke a purulent exudate and change the pseudocyst into an abscess. Pseudocysts often rupture into the lesser peritoneal cavity, or may dissect ventrally between the leaves of transverse mesocolon, and occasionally discharge their contents into the colon or adherent loops of small intestine. In many instances of acute pancreatic necrosis the onset is severe and death may follow within a very short period of time. This is illustrated in another patient in which the diagnosis of acute hemorrhagic pancreatitis was proven by necropsy.

Case 2. L. B. (C. G. H. #155349). This 29-year-old unmarried colored female claimed that she had always been perfectly well until noon on December 6, 1947. She denied ever having noted previous indigestion, abdominal pain, or jaundice. The night before she had had "a few (2) drinks." After arising in the morning she vomited twice and had a normal bowel move-

ment, but she neither considered herself sick nor experienced any pain until three hours before admission. About noon, December 6, 1947, while riding on a streetcar she was suddenly seized with a severe epigastric pain, which was dull and constant. It radiated around the left rib margin and directly through the abdomen to the back and left flank and in addition spread diffusely over the entire abdomen. After the onset of the pain the patient noted no nausea or vomiting. Her pain was slightly relieved if the patient sat upright.

When first seen in the Receiving Ward, the patient complained of severe abdominal pain, but she showed no signs of shock. She preferred to sit up during examination. Her temperature by mouth was 96; pulse 86; respirations 22; and blood pressure 120/80. She was not obese and appeared well-developed. Her abdomen was scaphoid and was markedly tender and rigid throughout, especially in the epigastrium. No masses could be felt, and no peristalsis was heard. Examination of the pelvic organs and rectum revealed diffuse tenderness which was referred to the region of the umbilicus.

Emergency laboratory studies showed that the white blood cell count was 10,380, that the urine contained 1+ albumin and no sugar, bile, or microscopic elements. A serum amylase determination, made shortly after admission, was read at 680 units (normal 50-200 u.).

The admission diagnosis was acute pancreatitis, and the patient was sent to a surgical ward. While being examined in bed by an intern, nine hours after the onset of pain, the patient suddenly sank back; her eyes rolled up and after two brief clonic movements she expired. Prior to this terminal episode she had been conscious and alert.

A postmortem examination performed two hours after death confirmed the clinical impression. Acute hemorrhagic pancreatitis with focal fat necrosis was found. There were 150 cc. of cloudy sanguinous fluid in the pelvis, and the lesser omental bursa contained a small amount of cloudy, sero-sanguinous fluid. The retroperitoneal tissues about the pancreas were edematous and hemorrhagic; and fat necroses were scattered over the surfaces of the pancreas and neighboring omentum and mesenteries. The pancreas, firm and slightly enlarged, contained many small coalescent focal hemorrhages and fat necroses. The pancreatic ducts were dilated, injected, and edematous, but no point of obstruction could be found. The following points are of etiological interest: the main pancreatic duct entered the duodenum separately from the common bile duct; no lymphadenopathy in the region of the pancreas or extrahepatic biliary tract; normal gallbladder and common duct without evidence of cholelithiasis; slight edema and congestion of the mucosa in the second portion of the duodenum; no evidence of thrombosis in the large pancreatic blood vessels. The microscopic sections revealed focal areas of pancreatic necrosis with thromboses of neighboring small vessels. There were also foci of organizing and mature connective tissue in the pancreas. Marked fatty infiltration of the liver without evidence of cirrhosis was noted.

* * *

(3) Suppurative pancreatitis may occasionally result from a primary bacterial invasion of the gland, such as multiple metastatic abscesses transmitted by the blood stream or lymphatic vessels, or as suppuration extending directly from a neighboring purulent focus. In these instance, the purulent inflammation within the pancreas is usually only a manifestation of a generalized infection, and symptoms of pancreatitis, such as epigastric pain and vomiting, are masked by those of marked systemic toxicity.

Acute suppurative pancreatitis commonly refers to the supervention of bacterial organisms on the lesions of pancreatic necrosis and, occasionally, edema. Unless a febrile episode occurs in the course of convalescence, no clear-cut signs mark the beginning of suppuration, which can be identified mainly by an abnormal rise in fever and increased leukocytosis. The large pseudocysts of pancreatic necrosis unfortunately tend to become infected, and under such circumstances they create the serious problem posed by an intra-abdominal abscess. With virulent infection the subsequent course is stormy and frequently fatal, whereas a mild infection can often be effectively handled by the bodily defenses. These principles are well illustrated in another case with acute hemorrhagic pancreatitis which led to suppurative pancreatitis and a large retroperitoneal abscess on the right side.

Case 3. C. H. (C. G. H. #210690). This 73-year-old white male was admitted to the surgical service of the Cincinnati General Hospital on February 2, 1946, complaining of crampy abdominal pain. For about seven years prior to admission the patient had experienced intermittent attacks of sudden, steady, epigastric pain which lasted one to two hours before quickly disappearing. The attacks bore no relation to meals, were not associated with nausea and vomiting, and were separated by intervals of good health, varying from one month to a year. Bowel movements were regular and normal. All foods had agreed with the patient, especially fatty foods. The last attack began six days before admission with sudden generalized crampy abdominal pain. The patient vomited once before consulting his physician, who administered "a shot," which partially relieved the symptoms. The pain persisted as a colicky, non-radiating discomfort in the upper abdomen without associated vomiting. A daily "shot" from the physician tended to ease the pain without curing it. The patient had little desire for solid food but continued to drink liquids without difficulty. The bowels moved regularly until two days before admission, but flatus continued to be expelled. No fever or chills had been noted.

On admission, February 5, 1946, the temperature was 98, pulse 80, respirations 20, and blood pressure 140/68. The patient, a slightly obese, elderly white male, complained of moderately severe upper abdominal pain but was not in shock. The skin was warm and moist. The abdomen, slightly distended, presented a faint bluish discoloration, suggestive of a hematoma, about the umbilicus. Moderate tenderness without spasm or rebound tenderness was found in the epigastrium, especially over an ill-defined

mass in the right upper quadrant which extended across the midline to the left and inferiorly as far as the umbilicus. No tenderness was elicited in either costo-vertebral angle or along the lower ribs. Peristalsis was active, although moderate tympany was noted. The initial laboratory work revealed a hemoglobin of 13.5 grams and white blood count of 12,300. The urine contained a trace of albumin, no sugar, and one white blood cell per high power field. The stool was green brown and gave a 1+ guaiac reaction. The serum amylase was read at 235 units. The blood sugar was normal, 108 mgm. per cent. The admission roentgenograms of the abdomen suggested the presence of a right subphrenic abscess containing a small pocket of air. The tentative admission diagnosis was cholelithiasis with hydrops of the gallbladder. On the basis of the roentgenographic findings a perforated peptic ulcer with subphrenic abscess was considered the second most likely condition, while the diagnosis of acute pancreatitis with pseudocyst was also discussed. A barium enema the day after admission revealed downward displacement of the right half of the transverse colon.

The patient was given nothing by mouth and intravenous fluids. The temperature rose to 100°. Twenty-four hours after admission he was taken to the operating room. Under local anesthesia the abdomen was explored through a short, upper right rectus, paramedian incision. The mass, noted on admission, consisted of matted omentum flecked with fat necroses. The gallbladder was thought to be normal and free of stones. Through an opening in the gastrocolic ligament, the head of the pancreas appeared enlarged, swollen, and injected. By palpation it was markedly indurated and twice normal size. The capsule was incised, revealing soft, dark, necrotic pancreatic tissue. Three cigarette and three Penrose drains were inserted into the pancreatic substance and brought out through the main incision. The abdominal wound was closed with two through-and-through steel wire stay sutures. The postoperative diagnosis was acute hemorrhagic pancreatitis with necrosis. Staphylococcus albus was cultured from the necrotic pancreas.

Following operation the patient's fever rose to 103°, and he became disoriented. Penicillin was begun on the second postoperative day and continued for thirteen days, 15,000 units every three hours. Improvement followed gradually. At first the drainage from the wound was only slight, but after changing to a sanguino-purulent discharge it became profuse and frankly purulent within two weeks after operation. The patient was discharged on the twenty-fourth postoperative day, at which time the wound was still draining and a mass was still palpable in the right upper quadrant.

After discharge the patient was followed closely in the surgical out-patient clinic. On April 1, 1946, he was readmitted to the hospital to secure better drainage of a large intra-abdominal abscess. On April 2, 1946, the patient was taken to the operating room, where an exploration of the abdominal sinus tract was carried out under local anesthesia. A large amount of friable, black and white material was removed from the abscess. Postoperative diagnosis was pancreatic abscess.

Following the second operation the patient developed a shaking chill and subsequently a fever of 101°. The wound drained large pieces of necrotic tissue and profuse sanguino-purulent fluid. The skin of the abdominal wall became excoriated. On the seventeenth postoperative day he complained of pain and weakness in the right hip. On the twenty-first postoperative day there was a sudden onset of severe abdominal pain, rigidity, and absent peristalsis, followed by frequent vomiting of coffee ground material. The patient lapsed into coma and expired fifteen hours later. The discharge diagnosis was acute suppurative pancreatitis secondary to pancreatic abscess.

A postmortem examination performed nine hours after death revealed an acute suppurative peritonitis, secondary to the retrocecal rupture of a large peripancreatic abscess, containing about 1000 cc. of pus. This abscess, which communicated with the sinus draining onto the abdominal wall had dissected behind the right half of the transverse colon and had traveled downwards behind the ascending colon to the retrocecal region before perforating into the general peritoneal cavity. The head of the pancreas appeared normal, while the remainder was replaced by necrotic, dark green material, which was in continuity with the retroperitoneal abscess. The gall bladder and common duct both contained innumerable small stones, although there was little evidence of inflammation. The common duct was patent. Marked coronary sclerosis was also present.

DIFFERENTIAL DIAGNOSIS OF ACUTE PANCREATITIS

It becomes obvious that the differential diagnosis of acute pancreatitis is a most important problem to the clinician. Time is important since unnecessary delay may for a specific surgical lesion invite disastrous results. In this regard there are a number of upper abdominal and even lower abdominal surgical conditions of the acute variety which make the clinical diagnosis of acute pancreatitis very difficult. Some of the more common are acute cholecystitis, perforated peptic ulcer, acute intestinal obstruction, acute appendicitis, acute diffused generalized peritonitis, acute mesenteric thrombosis, and renal colic. On the other hand there are a few medical conditions which also simulate the classical picture of acute pancreatitis and which will require consideration before a differential diagnosis can be made. Some of these conditions are biliary colic and common duct stone, acute coronary disease, pneumonia, dissecting aneurysm of the aorta, and tabetic crisis. There are other conditions which may, under certain circumstances, be confused with the diagnosis of acute pancreatitis. Some of them are, diaphragmatic hernia with incarceration, the early development of herpes zoster on the left side, acute arthritis of the thoracic spine, traumatic rupture of the aorta, and, rarely, the crisis associated with advancing hemachromatosis.

TREATMENT OF ACUTE PANCREATITIS

Until recently acute pancreatitis was considered a surgical emergency, and either multiple incisions into the pancreas with drainage or drain-

age of some portion of the extrahepatic biliary tract (cholecystostomy or choledochostomy) were performed. On rare occasions surgeons have advocated drainage of both the pancreas and extrahepatic biliary tract. Many observers believed that surgical treatment of acute pancreatitis was unjustified and gradually a more conservative approach has evolved. This change of attitude was not abrupt, and there are still a few who advise surgical intervention. In general, surgical drainage of the pancreas or of the bile ducts during the acute stage of the disease has carried a mortality rate of about 50 per cent; whereas conservative attitude in the management of pancreatitis has reduced the mortality.

Since the serum amylase test usually confirms the correct diagnosis, failure to diagnose emergencies requiring surgery is less apt to occur, and therefore conservative therapy is not a dangerous program. Currently, conservative measures are advocated until complications which require surgical intervention, such as pancreatic pseudocyst, intra-abdominal abscess, or collections of pancreatic fluid arise. Associated regional gastro-intestinal or biliary tract lesions can be treated after the patient has recovered from the acute pancreatic episode.

NONOPERATIVE OR CONSERVATIVE THERAPY

Because no clinical method is available to differentiate acute edematous pancreatitis from acute hemorrhagic pancreatitis, the clinician must practice conservative measures on each patient entering the hospital. A period of close observation should indicate the general behavior of the disease, and usually with four to six days the clinical course becomes fairly well established.

Conservative treatment is specifically concerned with two problems: (1) To institute measures which will diminish exocrine pancreatic secretion; and (2) to allay spasm of the sphincter of Oddi.

(1) Since food in the stomach stimulates pancreatic secretion, the patient, at bed rest, should receive nothing by mouth. In order to prevent gastric juice (chiefly hydrochloric acid) from affecting pancreatic secretion, continuous gastric aspiration should be instituted early and maintained as long as indicated, changing the Levine tube periodically. Since both hyperglycemia and hypoglycemia may affect pancreatic excretory function, control of the blood sugar level by the combined use of intravenous glucose and administration of insulin is important. Pain is best controlled by the use of demerol which has an atropine-like action and therefore does not stimulate the vagus nerve. Atropine paralyzes the cholinergic nerve fibers, which excite pancreatic secretion. Ephedrine also will diminish pancreatic secretion (Craft).[11] Morphine should be avoided when possible because it usually fails to control pain and stimulates pancreatic secretion (Elman[12] and Popper[13]).

(2) Antispasmodics such as atropine and nitroglycerine may aid in reducing spasm of the sphincter of Oddi. Novocainization of the paravertebral sympathetic ganglia may diminish pancreatic function and may also inhibit the spastic contractions of the sphincter of Oddi. Several authorities have advocated this procedure early in the course of the disease (Popper[14] and Gage[15]).

Water and electrolyte balance can be maintained by the parenteral administration of physiological salt solution, blood plasma, and whole blood if indicated. Landsteiner[16] (1900) referred to the fact that an antitryptic factor was present in the albumin fraction of blood. One might assume that large quantities of blood plasma, or more specifically the albumin fraction, may prove beneficial in those patients who develop hemorrhagic (necrotic) pancreatitis. Random administration of solutions of glucose is contraindicated since hyperglycemia may stimulate pancreatic secretion. Calcium salts may be given intravenously to control tetany. Chemotherapy should be given to all cases of acute pancreatitis on a prophylactic basis.

As yet no analytical figures are available which indicate the effect of modern chemotherapy upon pancreatitis. For the prevention of suppurative disease of this organ we believe chemotherapy should be used in the treatment of acute pancreatitis.

Penicillin may be given at the rate of 300,000 units daily. The method and site of administration may be decided by the individual clinician. Streptomycin given intramuscularly at the rate of 0.5 gm. twice daily may be administered. Sulfa derivatives may be given intravenously in doses of 2.5 to 5 gm., but should not be given by mouth. Although in a majority of cases with acute pancreatitis bacterial cultures of the diseased tissue cannot be obtained, the condition is so serious that administration of chemotherapeutic agents remains practical and is justified.

OPERATIVE TREATMENT

Although most observers (Elman,[17] Abell,[18] Cole,[19] Morton,[20] Popper,[21] and others) agree on nonoperative treatment in the milder forms of acute pancreatitis (edematous variety), there is no universal agreement about the exact management of acute necrotic pancreatitis. In general, the consensus of opinion indicates that operative procedures are less favored now than in former years. Surgery is indicated when a localized collection of fluid becomes manifest, when an intra-abdominal abscess is apparent, when a pancreatic pseudocyst becomes palpable, or when an abscess develops in the lesser peritoneal

cavity. If indicated, operation should assure sufficient and adequate drainage of the complication but exploration should not be extensive. An abscess of the lesser peritoneal cavity is more difficult to diagnose and more difficult to drain adequately that one in the greater peritoneal cavity. Operative procedures should not replace the good therapeutic measures of conservative management. Gastric aspiration, transfusions of whole blood or plasma, and chemotherapy should be continued postoperatively.

Some observers state that cholecystectomy may reduce biliary pressure. Other groups argue that cholecystectomy should be done primarily, after which choledochotomy associated with prolonged drainage of the common bile duct (choledochostomy) is indicated (Mayo,[22] Archibald,[23] Judd[24]).

According to recent opinion, operations upon the neighboring gastrointestinal and extrahepatic biliary tracts in the presence of acute pancreatitis are inadvisable. Those holding this opinion prefer to wait for the pancreatic process to subside and, assured of this, to evaluate the status of the gallbladder, liver, stomach, and duodenum for the presence of such conditions as cholecystitis, cholelithiasis, choledocholithiasis, and penetrating peptic ulcer, which should then be corrected by surgical methods.

Cholangiograms obtained at operation (choledochotomy) may be used advantageously to demonstrate common duct obstruction, spasm of the sphincter of Oddi, and the common channel into the pancreatic duct system. When cholangiograms demonstrate spasm or obstruction of the sphincter of Oddi associated with a reflux of radio-opaque material into the pancreatic duct, section of the sphincter has been advised (Colp,[25] Doubilet,[26] Mulholland[27]). More work should be done in this field before we can draw final conclusions.

From this discussion it is apparent that definite rules regarding therapy cannot and should not be made. A logical approach to this problem may be found in the integration of the history, physical and laboratory findings, response to therapy, and clinical course of the individual patient. Careful observation of the patient will determine the best therapeutic course.

PROGNOSIS

The prognosis of acute pancreatitis can be considered grave. Any patient surviving the initial attack cannot be assured that future episodes will not occur. Recurrent attacks are observed in seven to 30 per cent of cases of acute pancreatitis. In pancreatic abscess or cyst formation, a persistent pancreatico-cutaneous fistula may occur. The islands of Langerhans may be so extensively damaged that diabetes occurs in about 11 per cent of the cases. Some patients suffer pancreatic asthenia (Whipple,[28] 1924) and die within a few weeks of the onset of acute pancreatitis. Liver disease, particularly fatty degeneration, may be a sequel of this syndrome.

Acute pancreatitis may be the precursor of chronic relapsing pancreatitis, of which the prognosis is poor. Chronic disability and invalidism from the severe persistent pain of this disease are the chief concern. Rehabilitation of these patients offers a challenge to the medical profession.

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Medical Treatment of Hyperinsulinism: With Report of A Case

HENRY J. JOHN, M. D.

THE clinical entity of hyperinsulinism may be classified either as functional, in which there is derangement of the regulatory mechanism of blood sugar, owing to various causes, largely unknown, or it may be anatomic, the result of a pancreatic tumor involving the islet tissue. The first type can be treated medically; the second requires surgery. For that reason, it is essential in each case to ascertain whether the symptoms are on a functional or anatomic basis, so that useless and damaging surgery may be avoided.

The case I am using to illustrate the value of this differentiation is extremely interesting in that the patient, a boy who is now seven years and nine months old, developed hyperinsulinism when he was only three years of age.

The Author

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CASE REPORT

In 1943, at aged three, a boy began to have attacks of vomiting, followed by unconsciousness and then convulsions. During the following three years, he had five such severe attacks. The diagnosis of hyperinsulinism was made by the family physician, in 1946, when the blood sugar was found to be only 21 milligrams per cent in one of these attacks. A glucose tolerance test shortly afterward showed a normal blood-sugar curve. A galactose tolerance test revealed no glycosuria. The basal metabolic rate was -7 per cent.

The child was placed on a high carbohydrate diet, a serious error in treatment, since carbohydrate stimulates the endogenous insulin production, which in turn produces more hypoglycemia, and thus a vicious circle is established. This is apparently exactly what happened in this case, for after five days on the high carbohydrate diet, he went into hypoglycemic coma, with a blood sugar of 23 milligrams per cent (Chart 1). He was seen the following day by a medical consultant who advised operation on the pancreas. This naturally upset the family and they took the child to the Mayo Clinic, where he was studied for five days. There, two blood-sugar determinations made after a fifteen-hour fast were both below 40 milligrams per cent. These reactions were controlled by intravenous administration of 10 cubic centimeters of 50 per cent glucose solution. The adrenalin test yielded a normal hyperglycemic curve. A diagnosis of hyperinsulinism was made, and exploratory operation advised, with the recommendation that if an islet tumor were not found, half or more of the pancreas should be resected.

This confirmation of the previous diagnosis and advice disturbed the family still more, but they promptly returned home to Cleveland with the patient. For the next two and one-half weeks, the child was in and out of the hospital every few days because of convulsions and unconsciousness. Glucose given intravenously would restore consciousness, but in a day or two, the same condition would be encountered.

It was at this point that I first saw the patient. He was then aged five years and eight months. His mother described the symptoms to me as follows: "He gets spells of vomiting or gagging when he awakes in the morning and then he slips away into sleep for a few minutes. Then he awakes and has spells of muscular contractions verging on convulsions and then I rush him to the hospital. The first time he was unconscious all day and was treated symptomatically. When I give him orange juice early enough, this usually brings him out of it. The blood sugar was taken only once during the attack and it was 21 milligrams per cent."

The first day I saw him, I checked the blood sugar three times, once before each meal. It was 40, 73 and 78 milligrams per cent, respectively. There were no symptoms on that day. From the history and the previous findings it seemed clear that the case was one of hyperinsulinism, and so the patient was admitted to the hospital for further study and treatment. I gave him a diet consisting of 140 grams of carbohydrate, 80 grams of protein and 124 grams of fat, with a total of 2000 calories. Accurate calculation was made of the food actually consumed; what he left on his tray was calculated and charted (Table 1). In addition to this diet, he was

Table 1.
CASE OF HYPERINSULINISM: TREATMENT IN HOSPITAL

Date	Carbohydrate Grams	Protein Grams	Fat Grams	Calories	Body Weight Pounds
August					
27	140	80	124	2000	37.8
28	115	71	130	1914	
29	141	68	154	2222	
30	153	68	153	2261	
31	148	80	122	2010	
September					
1	164	91	141	2289	
2	111	52	107	1615	
3	135	67	112	1816	
4	75	42	70	1098	
5	133	70	135	2027	
6	114	53	119	1739	
7	154	56	81	1569	
8	117	69	121	1833	
9	133	71	97	1689	
10	166	92	144	2328	
11	170	103	136	2316	
12	177	89	111	1663	40.0
13	(Discharged from Hospital)				

Submitted May 25, 1949.

was given ice cream or cream in ginger ale between meals, at 10 a. m., and at 2:30 and 9 p. m. This furnished an additional supply of fat in a form which was pleasant for the child to take. He stayed in the hospital for eighteen days (Chart 1). During this period his blood sugar,

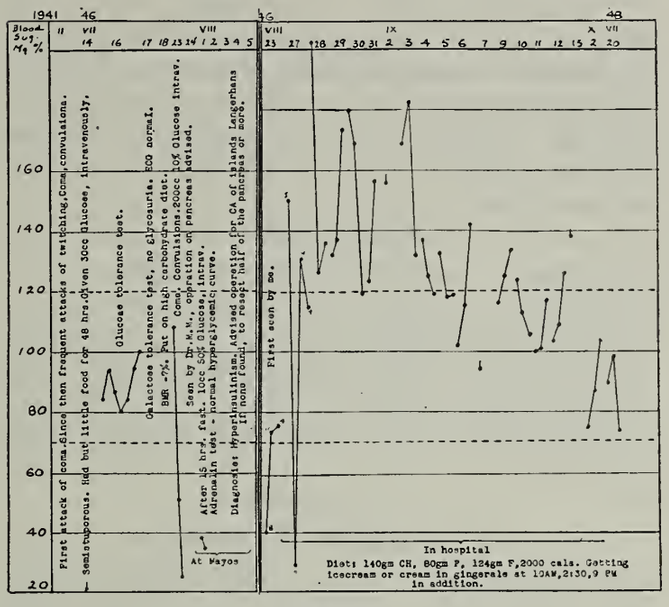


CHART 1

which was checked three times a day, before each meal, stayed well within normal limits, largely as the result of between-meal feedings. He received insulin only on the first day, when I gave him 6 units three times, after meals, when the noon blood sugar dropped to 29 milligrams per cent. Then insulin was discontinued, and the patient was treated by diet alone.

His progress was smooth. There wasn't a single hypoglycemic episode during his stay in the hospital, and none has occurred during the two years since. He began to gain weight and has developed normally (Table 2). He is now

Table 2.

CASE OF HYPERINSULINISM: FOLLOW-UP EXAMINATIONS

Date	Age	Weight	Height	Developmental Level
8-23-46 First Examination	5 yr. 8 mo.	41 lb.	44 in.	34
9-11-46	5 yr. 9 mo.	40 lb.	44 in.	32
12- 2-46	5 yr. 11 mo.	42 lb.	45 in.	37
7-20-48	7 yr. 7 mo.	52 lb.	49.5 in.	61

a freckled youngster, normal in all respects, going to school and partaking of all the activities of a youngster of his age.

In this instance, dietary management solved the problem, and I believe it is safe to say now that the case is one of functional hyperinsulinism and not a tumor of the islands of the pancreas.

DISCUSSION

We have been using the term **hyperinsulinism** to designate a clinical condition of nervousness, hunger, sweating, in the presence of a low blood sugar. Sometimes there is also muscular twitchings and convulsions and a drift into an unconscious state, as in the present case. The term **hyperinsulinism** is not accurate, since this means overfunction of the islands of Langerhans, that is, too much insulin in the blood stream owing to overproduction; often the symptoms are due rather to a derangement of the regulatory mechanism. However, clinically this term has come to denote a certain symptom complex, and it is likely that it will continue to be used.

The clinical picture suggests the diagnosis; blood sugar determination either confirms or eliminates it. When a clinical diagnosis of hyperinsulinism is made, then it becomes necessary to determine whether it is being caused by a functional disturbance or a tumor of the islands of Langerhans. On the basis of my own experience, I believe that the differentiation can be made by a trial of medical treatment with a moderate carbohydrate, high fat content, with or without supplementary insulin, as indicated in the individual case.

The first case of hyperinsulinism I observed was reported in 1925.[1] The patient had taken too much insulin, which produced a clinical picture resembling that of hyperthyroidism. When the insulin was properly adjusted, all symptoms disappeared. In 1931,[2] I reported a case in a physician, aged sixty-one years. About two years earlier, he had had a severe loss of weight (41 per cent) owing to diabetes and he also had hyperthyroidism, septic teeth and tonsils and hypertrophic cirrhosis of the liver. Under treatment, his diabetic condition improved rapidly; after sixteen months, all insulin was discontinued and his blood sugar remained normal on a liberal diet. Later, he began to suffer from attacks of hypoglycemia and finally was brought to the hospital in an unconscious state. His blood sugar was 30 milligrams per cent, and he died that same day, despite liberal intravenous administration of glucose solution. The autopsy showed hypertrophy of the islands of Langerhans. In this case, there was an extreme shift from diabetes to spontaneous hyperinsulinism.

About this time, with the increasing recognition of hyperinsulinism as a clinical entity, many physicians in this country developed great enthusiasm for surgical treatment of all types of cases of moderate to severe hypoglycemia with some symptoms resembling those of hyperinsulinism. This, I believed, was a dangerous teaching, for operative mortality in surgery of the pancreas naturally would be high in the hands of surgeons lacking experience in this special field, and thus many lives would be sacrificed. Recognition of this danger led me to try to find some other answer to this problem. Out of this study came my publication[3] on the medical treatment of this condition with a relatively low carbohydrate and high fat diet, along with administration of insulin a half-hour after each meal. The underlying principle of this treatment is to supply exogenous insulin

which decreases the need for endogenous insulin and thus puts the overworked islets of the pancreas at rest. In the first case in which this method of treatment was used, a complete restitution of normal function was achieved in a patient whose symptoms were severe and of long duration. On the basis of this satisfactory result, I carried out further studies along this line and published subsequent reports in 1934[4] and 1935.[5]

Thus far, I have observed twenty-five cases that I have treated medically, with no failure. I believe that the anatomic type of hyperinsulinism will not respond to medical treatment, but I have not been able to prove this point myself, since in all the years of work on this subject, I have not as yet encountered a case with island tumor. It remains for others to supply this information. If it should be proved that the anatomic type of hyperinsulinism will not respond to medical treatment, then medical treatment of the type I have used will provide a differential diagnosis of these two conditions, and should eliminate much unnecessary and dangerous exploratory surgery.

The symptoms of hyperinsulinism may continue for several years and remain fairly constant or they may gradually become more severe. Just because they become more severe is no proof that an island tumor is present. In two cases I have studied, the symptoms became more severe with time, and yet both were of the functional type. However, if symptoms should increase in severity rapidly, I should feel that this is presumptive evidence for a tumor, but it still would have to be proved before operation is advised.

The importance of a conservative approach to the problem of hyperinsulinism is well illustrated in the case reported here, which is typical of many others throughout the United States. Very able physicians with much clinical experience diagnosed his condition as probably due to a tumor of the islands of Langerhans and advised operation. His clinical course subsequently indicates that he did not have an island tumor, for his recovery was complete on medical treatment alone. It furnishes food for thought to wonder what his status would be today had he been subjected to operation, and if no tumor were found, half or more of his pancreas had been resected.

SUMMARY

A case of functional hyperinsulinism is described in a little boy who was three years of age when he began to have the typical symptoms of this condition. I saw him first when he was five years and eight months old, at which time his symptoms were severe, consisting of muscular twitchings, convulsions and unconsciousness. These symptoms were so severe and so frequent that he was constantly in and out of the hospital and when at home was under the care of three special nurses. Two different medical consultants advised operation for a tumor of the islets of Langerhans, with the recommendation that if no tumor were found, half or more of the pancreas should be resected. On medical treatment with a diet of moderate carbohydrate, high fat content, the patient responded perfectly, all the symptoms subsided and two years later he is entirely well, normal in every way.

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An American Experience

During my tour of the United States, I went into one large department and was shown the latest and most expensive equipment operated in conjunction with a photo-electric cell, the latter replacing the brain of the technician. The films were processed in an automatic developing unit, from which they issued as a finished product. I asked to be shown the next unit, and in reply to the question, "What is that?" was given the answer. "The machine for turning out the reports." "Take a seat and wait a few minutes," I was instructed; "I think we can show you that." A junior member of the staff appeared a few minutes later, took out a stamping machine from a cupboard, and began to stamp a large pack of reports. One of these was handed to me with the remark, "Does that satisfy you?" The report sheet with the name of the patient had been stamped with the report "Normal" and the radiologist's signature. On inquiry I was told that about 80-90 per cent of the reports were of this nature. I said, "Now, this is interesting for I have just come from San Francisco, where the President of the North American Radiological Society gave an address in which he said that three of the leading radiologists of America had examined a large series of radiographs and their reports showed a difference of opinion amounting to something like 30 per cent." I asked whether it would not be better simply to stamp all the reports "Normal," for then we should have a discrepancy of only between 10 and 20 per cent; or would it not be advisable to avoid radiology entirely owing to its expense: probably the best thing would be for clinicians to use radiology intelligently and thus cut down hospital expenses and treatment of the patient.—James F. Brailsford, M. D., British Medical Journal, No. 4630, October 1, 1949.

New Modified Protamine Zinc Insulin (NPH-50)

THOMAS P. SHARKEY, M. D., and HARRY E. KING, M. D.

WHEN protamine zinc insulin was introduced in 1937 it marked an important advance in the treatment of diabetes. It eliminated the necessity for multiple injections of insulin, afforded better control in most cases, improved the general health of the patient and caused almost complete disappearance of retardation of growth and hepatomegaly.[1]

Protamine zinc insulin, however, had certain deficiencies. In most children and in patients with severe diabetes, it did not control the glycosuria and hyperglycemia throughout the day, especially after meals. The use of protamine zinc insulin is not without potential hazards because of the insidiousness of the onset of hypoglycemia. When soluble insulin was added to protamine zinc insulin in the production of an insulin mixture, larger doses of soluble insulin than protamine zinc insulin were necessary because of the excess of protamine in protamine zinc insulin. While good diabetic control could be maintained in many patients on such mixtures, premixed solutions are not stable for any length of time[2] and the resultant difficulties arising from the mixing of the insulins cannot be mastered by all patients.

During the past few years modified forms of protamine insulin have been studied. MacBryde[3] reported good results with the use of such an insulin prepared by Eli Lilly and Company, and which is designated "NP-50."

Krayenbühl and Rosenberg,[4] in Hagedorn's laboratory, developed the method of preparing crystals of protamine zinc insulin. This new modified insulin has been prepared by Eli Lilly and Company as previously reported by Peck.[2] This new modified protamine insulin has been designated "NPH-50." "N" refers to the neutral reaction (pH 7.2), "P" to protamine, "H" to Hagedorn and "50" to the amount of protamine. The amount of zinc is relatively small. As now prepared the amount of protamine used per 100 units of NPH-50 insulin is 0.50 mg. The preparation of protamine zinc insulin now being marketed contains 1.25 mg. of protamine in 100 units of insulin.

Through the courtesy of Dr. F. B. Peck of Eli Lilly and Company, we have had an opportunity to study the action of this new insulin for the past 18 months. To date we have used this insulin on 28 patients. The ages varied from 6 to 73 years, with a mean of 48.2 years. The duration of diabetes varied from 0.1 years to 21.1 years with a mean of 6.9 years.

All patients were considered to have severe or labile diabetes as manifested by excessive hyperglycemia and glycosuria, or by frequent severe hypoglycemic reactions. (All had previously been regulated in the hospital on other types of insulin.) These same patients were again regulated in the hospital with NPH-50 insulin and have since been followed at frequent intervals in the office. The diet was a fixed weighed diet averaging 178 grams of carbohydrate, 94 grams of protein and 102 grams of fat, with an average caloric value of 2006 calories. Qualitative urinalyses were performed every two hours from 6:30 a. m. to 9:30 p. m. The 24-hour specimen of urine was measured and a quantitative sugar determination together with acetone and diacetic acid levels were computed daily. The daily quantitative amount of glycosuria was also computed. Frequent blood sugar determinations, both venous and capillary, were done throughout the day and occasionally at night. Upon returning to the office, the patients presented a record of four urine tests daily for the first week out of the hospital and in some cases for a longer period of time. Following this a daily staggered urinalysis was recorded, as well as the time of any hypoglycemic reactions. A true blood sugar determination by the Somogyi-Nelson method and a urinalysis was always made during each office visit.

GENERAL ACTION

As can be seen by Chart I, the action of NPH-50 insulin extends through 24 hours. It is an advantage that NPH-50 insulin does not have the marked overlap of action characteristic

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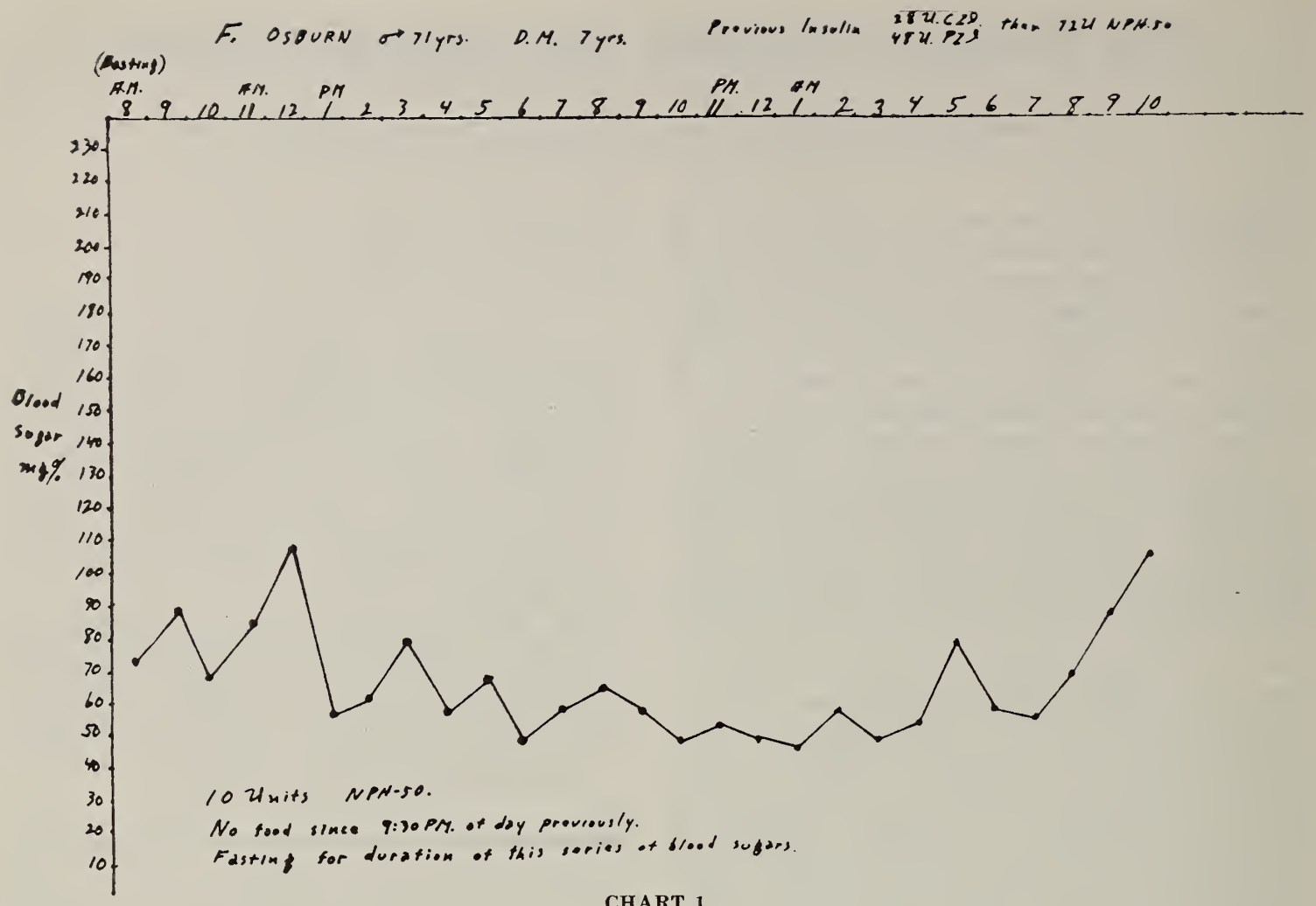


CHART 1

of protamine zinc insulin. It begins to exert its effect much sooner than protamine zinc insulin and the effect of NPH-50 insulin on the blood sugar can be noted within 2 to 4 hours after it is injected. Its maximum effect appears to occur from 12 to 24 hours after injection but a distinct hypoglycemic effect can be discerned in 6 to 8 hours after it is given. The weakest point of action of NPH-50 insulin is within the first four hours after injection, namely, from the period following breakfast until noon.

Of the 28 patients, 16 were controlled following a single dose of NPH-50 insulin. The average daily dose of NPH-50 insulin was 25 units. Of the 16 patients eight had previously taken an average of 12 units of crystalline zinc insulin and an average of 13 units of protamine zinc insulin by separate injections before breakfast, or a total average of 25 units of the two kinds of insulin daily. For these eight patients the average dose of NPH-50 insulin was 26 units. Of the other eight patients controlled by a single dose of NPH-50 insulin, one had previously taken protamine zinc insulin, while two had taken multiple doses of crystalline zinc insulin, and five had not taken any insulin previously. The control of the diabetes was better and there were fewer reactions when NPH-50 insulin was employed than on their previous insulin program.

As with protamine zinc insulin all patients cannot be regulated by a single dose of NPH-50 insulin. The action of NPH-50 insulin closely simulates the action of mixed protamine zinc insulin and crystalline zinc insulin except for a lag-period from breakfast until noon when NPH-50 insulin is used. Some patients who reveal excessive hyperglycemia and glycosuria particularly during this period may require accessory crystalline zinc insulin or regular insulin. One distinct advantage of NPH-50 insulin over protamine zinc insulin is that since there is a smaller amount of protamine in NPH-50 insulin, less regular or crystalline insulin is adsorbed when the two are mixed.

REGULAR OR CRYSTALLINE ZINC INSULIN ADDED

In those patients showing excessive hyperglycemia and glycosuria before noon, regular or crystalline zinc insulin can be added to NPH-50 insulin in sufficient amounts to prevent such excesses. We found in our group of patients that 12 could not be controlled by NPH-50 insulin alone but required the addition of crystalline zinc insulin. Of these 12 patients, six had previously taken an average of 9 units of crystalline zinc insulin and 13 units of protamine zinc insulin given separately. They were controlled on a mixture of crystalline zinc insulin averaging 12 units and NPH-50 insulin averaging 21 units. The other six patients had not taken insulin previously and were controlled on an average of 11 units of crystalline zinc insulin and 13 units of NPH-50 insulin given in a single injection. During the past 18 months we have found it much simpler to adjust any

changes in the insulin mixture of crystalline zinc insulin and NPH-50 insulin than was the case with the mixture of crystalline zinc insulin and protamine zinc insulin. In the former mixture the crystalline zinc insulin dosage has varied to control the period from breakfast until noon, and sufficient NPH-50 insulin was given to control the rest of the day and night. During infections and other complications the mixture of crystalline zinc insulin and NPH-50 insulin was more easily varied.

REACTIONS

The reactions to NPH-50 insulin are not so insidious as are those which occur with protamine zinc insulin. When using NPH-50 insulin reactions occur most frequently in the afternoon and early morning hours. These reactions can be largely prevented by giving a mid-afternoon feeding and a bedtime feeding.

A mid-afternoon feeding of 100 to 150 grams of orange or its equivalent should be given because of the tendency for NPH-50 insulin to produce hypoglycemia at this time. A bedtime feeding should always be given to avoid hypoglycemia through the night. When taking NPH-50 insulin it may be necessary to give from 20 to 40 grams of carbohydrate combined with protein at the bedtime feeding to offset nocturnal hypoglycemia.

When compared to the reactions of protamine zinc insulin, those due to NPH-50 insulin are not so severe or so prolonged. In our experience less carbohydrate has been necessary to alleviate the reactions due to NPH-50 insulin than is required to overcome those due to protamine zinc insulin.

Contrary to the observations of other authors we have not been able to control the great majority of our patients with a single dose of NPH-50 insulin. This may be due in part to our selection of patients. Mild diabetic patients may be controlled by a single dosage of almost any kind of insulin and an evaluation limited to such a group of patients would be futile.

In our experience with some individuals the dosage of NPH-50 insulin was greater than the amount of insulin that they had taken previously. The better control of the diabetes and more uniform absorption of the NPH-50 insulin compensated for this fact however.

THE DIET

At times it is necessary to redistribute the carbohydrate of the diet of patients employing NPH-50 insulin because of the relatively slower absorption of NPH-50 insulin between breakfast time and noontime. It may be necessary to reduce the carbohydrate of the breakfast meal, or to transfer some of the carbohydrate to another meal. Variations in diet and exercise exert the same effect with NPH-50 insulin as with other insulins.

SUMMARY AND CONCLUSIONS

1. During the past eighteen months we have studied the effect of NPH-50 insulin on 28 diabetic patients both in the hospital and in office practice.

2. While NPH-50 insulin is not yet the ideal insulin, since it will not control all diabetic patients without the use of accessory insulins, it does appear to afford better control than protamine zinc insulin.

3. The absorption of NPH-50 insulin when used alone is relatively slow between breakfast and noontime, reaches its maximum effect in the afternoon and night and lasts through twenty-four hours.

4. In our series of patients, NPH-50 insulin controlled satisfactorily 16 patients when used alone. It was necessary to add crystalline zinc insulin in 12 cases.

5. The control of the diabetic state was better when NPH-50 insulin was used alone or mixed with crystalline zinc insulin than had been noted previously when crystalline zinc insulin and protamine zinc insulin were used.

6. Insulin reactions to NPH-50 insulin or to the mixture of crystalline zinc insulin and NPH-50 insulin were not so severe or so prolonged as those noted with the same patients who had used crystalline zinc insulin and protamine zinc insulin previously.

7. A mid-afternoon feeding and a bedtime feeding should be given to patients taking NPH-50 insulin. Only occasionally is it necessary to give a mid-morning feeding to patients taking mixtures of crystalline zinic insulin and NPH-50 insulin.

8. It is often necessary to redistribute the carbohydrate of the diet in patients taking NPH-50 insulin.

9. It is easier to adjust the dosages of mixtures of crystalline zinc insulin and NPH-50 insulin than it is to regulate the dosages of mixtures of crystalline zinc insulin and protamine zinc insulin. This is a valuable asset when infections or other complications occur.

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A Summer Camp for Diabetic Children

E. PERRY McCULLAGH, M. D., PHILIP W. RUSSELL, M. D., and R. E. SCHNECKLOTH, M. D.*

THE management of diabetes mellitus in children at home is frequently a confusing and discouraging problem for the child and his parents. A summer camp alleviates this problem, and provides an ideal situation for the regulation of diabetes. Careful medical direction of the normally active child at camp enables a more accurate adjustment of insulin and diet than can be accomplished at home or in the hospital. The diabetic child also profits from the recreational advantages of an outdoor life, which might otherwise be denied. The opportunity to form friendships with other diabetic children promotes the growth of a mature acceptance of his disease. In addition, his parents are permitted a well-deserved and often expressed, relief from their medical responsibility.

In 1929, Dr. Henry J. John established Camp Ho Mita Koda on a 40-acre wooded tract, 30 miles east of Cleveland, near Newbury, Ohio. The camp is incorporated as a nonprofit organization, and is supported in part by interested organizations. Accommodations are available for 60 children, who may spend one to two months in camp.

Campers are assigned to one of six screened cabins, accommodating 10 children according to age and sex. The cabins are arranged on either side of a landscaped plot, within 50 yards of the central lodge. This contains the "Great Hall," the center for indoor activities, as well as a library, kitchen, dining hall, laboratory, and infirmary. The recreational area provides a swimming pool, craft shop, baseball diamond, tennis court, volleyball court, archery range, outdoor theater, and several camping sites. Complete electrical and sanitary facilities are available.

The nonmedical personnel includes the camp director, seven counselors, two cooks, and the maintenance staff. The medical staff consists of a medical director who visits the camp daily, a resident camp physician, two registered nurses, and two dietitians. The infirmary is completely equipped for medical and minor surgical emergencies. Seriously ill patients are transferred immediately to a hospital in Cleveland.

During the summer of 1949, 58 children, 28 boys and 30 girls, were at camp. Their ages ranged from 5 to 16 years. Forty-six children stayed four weeks, while 10 remained for both camp sessions. Two children departed after two weeks because of homesickness.

The daily medical program began with "insulin parade" at 7:30 a. m., when insulin was administered by the nurses. Urine specimens were examined for sugar and acetone before breakfast, supper, and bedtime. Fasting and preprandial blood specimens were drawn when necessary. Close supervision by camp counselors enabled prompt treatment of daytime insulin reactions. Visits to each child's bedside by a nurse or the physician at midnight, 3 a. m., and 6 a. m., minimized the threat of night insulin reactions.

The recreational program offered a daily choice of activities to each child. The regulation of the child's diabetes altered to some degree the final selection of his daily activities. Group participation under constant counselor supervision provided the means for modifying somewhat the amount of each child's exercise.

CLINICAL EXPERIENCE AT CAMP

Hyperglycemia. The modified Myer-Bailey method was used to determine venous blood sugar levels. Approximately 25 determinations were made daily by the camp physician. Preprandial blood specimens were obtained when necessary for control. Individual campers sustained 3 to 33 venipunctures during their camp stay; an average of 11 venipunctures per camper were performed during the camp period. During the first three days of camp, 35 children had fasting blood sugar levels above 200 mg. per cent. The average highest blood sugar level during this period was 267 mg. per cent.

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* The authors were medical director and resident physicians of Camp Ho Mita Koda, respectively.

Five children entered camp with fasting levels exceeding 500 mg. per cent. The average of the highest level during each child's last week in camp was 195 mg. per cent.

Urine tests. "Clinitest" tablets were used for qualitative estimation of urine sugar on specimens collected before breakfast, supper, and bedtime. Additional noon specimens were obtained from children requiring closer control. The Rothera method for acetone was performed on all specimens. Acetonuria was present during the first three days in 24 campers, while 11 gave isolated positive tests for acetone at some time during the remainder of their camp stay. Urinalyses on all children revealed no evidence of albuminuria.

INSULIN

The average insulin doses on admission and discharge are tabulated below (Table I). Insulin

TABLE I

Age (Years)	Number of Campers	Duration of Diabetes (years)	INSULIN (Total units)	
			Admission	Discharge
5-6.9	3	2.8	19	25
7-8.9	10	3.2	26	35
9-10.9	11	3.4	29	39
11-12.9	14	4.4	33	46
13-14.9	16	4.2	55	60
15-16.9	4	5.9	53	55

requirements of many younger children were increased at camp despite their increased exercise. This change reflects improved control of their diabetes. It is possible that camp observation offered an opportunity to establish the increase in insulin requirements that ordinarily occurs with growth of the child.

All but two children had been treated at home with protamine zinc and regular insulin; these exceptions had received globin and regular insulin. At camp it became apparent that a single injection of mixed protamine zinc and regular insulin before breakfast was most effective, and 41 children received this regimen. Thirteen children received protamine zinc and regular insulin by separate injections before breakfast, and four got protamine zinc insulin alone.

The medical aim at camp was to maintain normal fasting blood sugar levels without inducing insulin reactions. Satisfactory control consisted of fasting levels of 80 to 160 mg. per cent, and was achieved in 26 children during their last week in camp. Urine specimens showing a blue or green test throughout the day were considered satisfactory, and the average number of yellow, orange, or red urine tests among the last 20 urine specimens of each child was seven.

Determination of the optimal dose of protamine zinc and regular insulin to be given before breakfast was achieved by altering the amount of regular insulin to control afternoon glycosuria, and the amount of protamine zinc to control fasting hyperglycemia. The insulin dose was manipulated cautiously, for many children were sensitive to an increase of only two to four insulin units. Whenever a sustained increase in glycosuria was observed in a child, an additional two to five units of regular insulin was given to him before each meal, at the time when a yellow, orange, or red urine test was obtained. These children provided an extra urine specimen before lunch, and continued to receive additional preprandial insulin until better control was established. Thirty-six children were controlled in this manner during short periods of their camp stay, as they exhibited the wide fluctuations characteristic of juvenile diabetes.

Six months after camp, response from 45 children indicates that 21 children are still receiving the same total dose of insulin prescribed at camp. Eleven children whose insulin was increased at camp are receiving even higher doses. The insulin doses of 13 children have returned to that prescribed before camp. Although camp diets increased the daily available glucose of 28 children by an average of 48 Gm., the present diets cannot be evaluated. The above data suggest that the anticipated yearly increase in insulin doses of growing children can be effectively established during a summer camp season.

DIETS

There was great variation in diets that had been prescribed before camp. Seventeen children had been receiving unrestricted diets. Many children, who had received calculated diets at home, admitted that extra food was frequently consumed, at times surreptitiously but often with the tacit approval of their parents. It was not unusual to find food and candy in packages sent to children from home.

Past experience at camp had shown the impracticability of serving diets separately calculated for each child. One of five camp diets was selected for each child, approaching as nearly as possible his basal requirement plus 50 to 100 per cent for activity. The percentage of available glucose present in the home diet was a minor factor in the selection of the camp diet, inasmuch as there was a wide range of calories per kilogram in the home diets of every age group.

Sample trays of each diet were carefully weighed at every meal. Duplicate trays were closely approximated. The caloric value of uneaten food was replaced by bread or graham crackers; ice cream, soft drinks, nuts, popcorn, and candies were given on special occasions and calculated into the diet.

Interval feedings consisting of milk and graham crackers were given at 3 p. m. and

bedtime. An additional 10 Gm. of carbohydrate, in the form of graham crackers, was given to those campers who showed blue or green urine tests at bedtime. This procedure significantly lowered the number of insulin reactions at night, which had been a primary problem during camp sessions in previous years.

In order to satisfy the energy and appetite requirements, from an increase in physical activity, the caloric intake and bulk of food was often augmented early in the camp stay. On discharge the total caloric content of diets ranged from 1999 to 3390, or 40 to 60 calories per kilogram. The amount of protein ranged from 87 to 131 Gm., and approached 3 Gm. per kilogram. Carbohydrate to fat ratios varied from 1.75:1 to 2:1, and the total amount of carbohydrate ranged from 180 to 325 Gm.

Insulin reactions. The management of insulin reactions was a major problem at camp. In those children with labile diabetes, the prevention of reactions was discouraging. The effect of physical activity on such campers made stable control extremely difficult. Many mild reactions during play were quickly treated with oral glucose by an alert counselor. A total of 172 moderately severe reactions were recorded during the two-month camp period. Four reactions required intravenous glucose, and one responded to an injection of epinephrine. Nineteen reactions occurred at night or before breakfast, but only two of these required intravenous glucose. The recognition of sham reactions was occasionally a source of confusion. The absence of hypoglycemia in blood specimens obtained at such times quickly clarified this issue.

PHYSICAL FINDINGS

Upon examining all campers on admission, one boy was found to have hepatomegaly, probably caused by fatty infiltration of the liver. Three children entered camp with symptoms and laboratory findings indicating diabetic ketosis; these were controlled adequately during the first week. One boy who was convalescing from trichinosis had hepatomegaly and splenomegaly. Funduscopic examinations of all campers by Dr. Roscoe J. Kennedy revealed two pinpoint retinal hemorrhages in a 13-year old boy who had had diabetes for 11 years. No other campers had evidence of diabetic retinopathy.

The admission and discharge height and weight of each child were plotted graphically on a Wetzel grid. This procedure indicates which Grid channel of growth the child is following, and permits early recognition of deviations from normal growth and development during succeeding years. The distribution of campers between the obese channel A_4 and the underweight channel B_4 is tabulated in Table II. The growth channels of 14 children were changed while at camp. Six of these children were below their estimated ideal weights, and gained an average of 6 lbs. to attain a more satisfactory channel. Two children above their ideal weights lost an average of 4.5 lbs. shifting to their proper channels. Six children who were initially above their ideal weights continued to gain at camp. The boy who was convalescing from trichinosis remained in channel B_4.

TABLE II

Admission Grid Channel	Number Campers	Number Campers Shifting Channels: Toward Ideal (wt. gain)	Toward Ideal (wt. loss)	Away from Ideal (wt. gain)
A4	5	----	----	----
A3	1	----	----	1
A2	5	----	1	----
A1	12	----	1	2
M	11	1*	----	3
B1	12	----	----	----
B2	10	4**	----	----
B3	1	1	----	----
B4	1	----	----	----
Total	58	6	2	6

* Shift of 2 growth channels
** Two children shifted 2 channels
All other shifts were one channel only.

CAMP ADJUSTMENT

The majority of campers made an excellent camp adjustment, although for many it was their first experience away from home. Diabetic routine was often accepted with less resentment at camp than at home. The adolescent children were more apt to break their diets and to reject the diabetic routine than were the younger children. Psychometric studies were made at camp when indicated, and were an aid in establishing better rapport with those campers. One child showed bizarre psychopathic behavior with complete rejection of diabetic control.

SUMMARY

A short description is given of a summer camp for diabetic children in Ohio, outlining its facilities and the methods of management used during the 1949 season.

Clinical experience is considered briefly, including remarks about the blood sugar tests, the type of insulin therapy used, and the readjustment of insulin doses and diets.

The complications of diabetes which were encountered included insulin reactions, ketosis, hepatomegaly, and in one child early diabetic retinopathy.

Follow-up studies indicate that insulin readjustments made at camp are valuable for many subsequent months.

It is evident that summer camping experience is of psychologic and therapeutic benefit to the diabetic child.

The Control and Treatment of Brucellosis

JOHN A. PRIOR, M. D.

A WIDESPREAD infection involving both man and animals, brucellosis is one of the major public health problems in the United States. It is of growing importance, more cases being reported in 1948 than ever before.[1] Morbidity and mortality statistics in man represent only the reported cases of this disease and for each known case there are undoubtedly others that fail to reach the attention of health officials. Also, brucellosis represents a major health problem in livestock, and is estimated to cost the cattle industry alone almost $100,000,000 each year.[2]

An understanding of the bacteriology and epidemiology of brucellosis is essential to a full appreciation of the problem of diagnosis, treatment and control. The causative agent is the *Brucella* bacillus of which there are three principal strains: *B. abortus*, *B. suis* and *B. melitensis.* [3, 4, 5] None of the strains is confined to a single species; thus, differentiation of strains on basis of host involved is not possible.

SOURCE AND MODE OF SPREAD

B. abortus has its principal reservoir in cattle and has replaced tuberculosis as the most serious problem with which the cattle industry has to contend. Most frequently involving the cow, it causes no particular clinical symptoms, but may result in abortion, sterility and diminished milk supply without evident mastitis. Large numbers of organisms may be found in the uterus, embryonic membranes and milk. Occasionally, bulls may be infected, resulting in sterility or a source of infection for the cows served. From contact with the fetus, placenta and membranes or by consumption of infected raw milk, the disease spreads to man. Since it is not highly invasive for man, *B. abortus* usually causes only sporadic cases. However, the first epidemic due to this organism has been reported recently.[6] Although *B. abortus* tends to cause the most benign form of the disease, it is the most common, and at times, may cause serious illness with some fatalities.

The natural reservoir of *B. suis* is in swine and is found most frequently in the middle west. Although abortion in sows may result, usually *B. suis* infection causes persistent localized lesions, e. g., in skeletal system and in testes. *B. suis* is more invasive for man than *B. abortus* and in this country results in a relatively severe form of the disease. It spreads to man by handling infected tissues or fluids of pigs or by infection of cattle from whom man contracts the disease.

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The Author

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B. melitensis has its natural reservoir in goats and sheep. Because the disease localizes in the udder, the animal otherwise remaining healthy, the principal mode of spread is by consumption of infected milk or milk products. Occasionally the disease may spread to cattle and swine. *B. melitensis* is very highly invasive for man and tends to cause a particularly severe illness.

Thus, man contracts brucellosis in three ways: (1) By consumption of infected raw milk or milk products; (2) by contact of skin with tissues, secretions and excretions of animals with brucellosis; and (3) occasionally laboratory workers may contract the disease in the course of their work. There is no known transmission from man to man.

AN OCCUPATIONAL DISEASE

Brucellosis is definitely a rural disease. It is estimated that more than 80 per cent of all patients develop the disease incident to their occupation as farmer, dairy worker, veterinarian and packing house worker. In a study of 1,564 cases in Iowa conducted[7] over a seven-year period, Jordan demonstrated that contact with infected animals is certainly the most important source of the disease. His figures show the incidence to be as follows: Farmers with animal contact, 17 per 100,000 population; packing house workers, 131.1; farmers' wives, 0.7; and city residents, 0.8.

Because of the lack of definitive or pathognomonic signs or symptoms, the possibility of brucellosis must be considered in all acute or chronic febrile illnesses. Weakness, sweating, chilliness, fever, anorexia and loss of weight are commonly present.[8] Generalized aching, headache, joint and back aches, insomnia and nervousness are less frequent manifestations. Cough, abdominal pain, constipation, rash and splenomegaly occasionally may be present. Thus, it will be seen that brucellosis is characterized by

a multiplicity of non-specific subjective complaints and by the absence of diagnostic physical findings.

The classic picture of bouts of undulating fever seldom is seen in this country. Usually, the onset is acute lasting several weeks to even several months. There may be gradual subsidence into complete recovery in some instances. More often the acute phase is followed by low grade chronic disease in which the patient will have recurrent bouts of fever every few weeks or months, although eventually the disease will burn itself out. A number of patients with chronic brucellosis never have had an acute phase.

Even though there may be history of exposure and signs and symptoms that suggest brucellosis, it is usually necessary to fall back on the laboratory for more conclusive evidence of its presence.

DIAGNOSTIC AIDS

Of all the laboratory procedures used in the study of brucellosis, blood cultures are the most valuable. It is only by culture of the causative *Brucella* organisms that the diagnosis can be established indisputably. It is well known that in some cases the *Brucellae* cannot be recovered even on repeated cultures. However, at least several attempts always should be made. Because growth on primary culture is difficult to obtain, every precaution should be taken to assure success. Generally, an enriched tryptose media works well and a portion of each blood specimen must be incubated at 10 per cent CO_2 tension since *B. abortus* will not grow on primary culture at normal atmospheric tensions. The three species of *Brucellae* can be differentiated only by: (1) dye tolerance, (2) sulfide production, (3) carbon dioxide requirements, and (4) elementary chemical analysis. Cultures should never be discarded as negative until observed for at least six weeks as these organisms are slow to grow. Our inability to readily isolate *Brucellae* in chronic brucellosis remains our greatest handicap in the study of this phase of the disease.

By the end of the second week of disease, agglutinins will appear in significant titer in the blood of more than 90 per cent of the patients.[3] The agglutination test is usually reliable if proper antigen and careful technique are used. A titer of 1:100 or above generally is considered of diagnostic significance. A significant titer often will be present if the patient has any fever and will be present in almost every patient in whom blood cultures are positive. Although frequent statements are made that agglutinins are commonly absent in chronic brucellosis, they are more apt to be present in significant titer if the patient has any elevation of temperature above normal. It is not possible to differentiate the three strains of *Brucellae* by means of agglutination tests.

In addition the presence of serum agglutinins may not be necessarily specific for *Brucellae* since significant titers may develop as result of infection with *B. tularense*[9] and following cholera vaccine.[10]

The opsonocytophagic index which is designed to measure the ability of the polymorphonuclear leukocytes to phagocytize *Brucellae* has been subjected to extensive clinical evaluation. However, opinions are still divided as to its usefulness. Active phagocytosis in 60 per cent or more of the white blood cells is considered by Huddleson[4] to indicate immunity while in the non-immune or the active case, little or no phagocytosis is present. Huddleson believes that it is a valuable diagnostic procedure and has worked out a rather extensive correlation of this test with the skin test. However, Spink,[11] Simpson,[12] Carpenter[13] and Dowling[14] feel that it is not reliable.

Since skin sensitivity develops soon after infection, the skin test has been widely used and misused as a diagnostic procedure. Brucellergen, which is a nucleo-protein derivation from *Brucella* organisms, has been used rather extensively as a skin test antigen. One tenth cc. of 1:2000 dilution is injected intradermally and is interpreted after forty-eight hours in the same manner as the tuberculin test. Definitely more specific are the heat killed vaccines.[15] One-tenth cc. of full strength vaccine is injected intradermally and interpreted after ninety-six hours. However, all skin test antigens may cause considerable local reaction and not infrequently after injection of such material, the patient's symptoms may be accentuated. In addition, skin tests may cause the presence of, or an increase in, agglutinin titers. It cannot be emphasized too strongly that positive brucellergen or vaccine skin tests mean nothing more than does a positive tuberculin test. A positive skin reaction means only that at some time the patient has been infected with *Brucella* organisms and tells absolutely nothing about the presence or absence of active or latent disease. In addition, a violently positive reaction means nothing more than does a weakly positive reaction except that in one the patient is much more sensitive than in the other. Far too many people with a few vague symptoms and a positive skin test are diagnosed and treated as having chronic brucellosis. Spink[11] states that "the skin test is the most abused procedure in the diagnosis of brucellosis."

Recent work suggests that the bactericidin test may develop into a valuable diagnostic tool. However, its full significance has not yet been determined.

Usually the blood count will reveal a normal or reduced number of leukocytes with a relative lymphocytosis.

TREATMENT

The treatment of brucellosis has presented a serious challenge to medical science for many

years. In 1936 Carpenter and Boak[16] reviewed the treatment of this disease and concluded that a successful method of treatment remained to be developed. Then, it was found that some patients with acute brucellosis responded favorably to sulfonamide compounds.

Combined streptomycin and sulfadiazine therapy later was found to be superior to the sulfonamides alone. In recent months the use of aureomycin in the treatment of acute brucellosis has been reported. The results have been very encouraging, in some instances truly dramatic, bringing the high fever of acute brucellosis within normal limits in two to three days,[17] including that due to the more malignant *B. melitensis*[18] that had responded only occasionally to combined streptomycin and sulfadiazine treatment. Spink[19] now suggests the use of 0.5 gram four times a day for 10 to 14 days. Toxic reactions are mild and seldom necessitate discontinuing administration of this dosage. Aureomycin appears to be definitely superior to any previous therapy and available evidence would indicate that this splendid new antibiotic is the current treatment of choice in acute brucellosis. In the event of relapse, a repeat course of aureomycin is usually effective. However, further study is needed to fully evaluate aureomycin. Heilman[20] has reported recently that the spleens of mice infected with *Brucella*, after treatment with aureomycin, still contained great numbers of organisms. Woodward[21] reported that chloromycetin appeared to be equally as effective as aureomycin in the treatment of acute brucellosis.

TREATMENT IN CHRONIC BRUCELLOSIS UNSATISFACTORY

The problem of treatment in chronic brucellosis still remains. Brucellin, a filtrate of pooled cultures of the three strains of *Brucella*, has been widely used in its therapy. Heat-killed or oxidized vaccines have their advocates. All are designed to stimulate antibody formation and as a result overcome the chronic disease as well as to decrease the hypersensitivity. There is considerable doubt that such measures achieve these desired results. A more rational approach to the problem instead would seem to be the use of some chemotherapeutic agent that would eradicate the disease from the body. Conclusive reports are not yet available on the use of aureomycin in chronic brucellosis. However, it is the hope of all students of brucellosis that if aureomycin does not prove effective, some other chemotherapeutic agent will soon solve this troublesome problem.

CONTROL MEASURES

Since brucellosis does not spread from man to man, the ultimate elimination of the disease in man is dependent upon the eradication of the reservoir of brucellosis in domestic animals. Every effort should be made to support the brucellosis control campaign of the Ohio Department of Health and the various veterinary organizations. Infected cattle should be destroyed where the percentage of reactors in a herd is small. Immunization of young stock with strain 19 of *B. abortus* should be encouraged at every opportunity. When considering the possibility of a patient's exposure to infected cattle, the physician should remember that simply because a farmer, dairy worker or livestock producer says that his cattle have been "Bang's tested" does not mean that his herd is free of brucellosis. Instead, he may have numerous infected animals and is participating in a program of vaccination of the young stock with the gradual elimination of the older infected animals over a period of several years. Brucellosis in goats, quite uncommon in Ohio, is proof of the effectiveness of a unified control campaign. However, where goats are infected, the problem is readily solved by slaughter. In swine the problem is much more difficult and so far, little effort has been expended in the elimination of the disease from this species. It is obvious that any program for the elimination of the animal reservoir of brucellosis will necessitate the combined support of the farmers, livestock producers, dairymen, veterinarians, meat packers and public health officials.

Pasteurization of all milk or milk products for human consumption will prevent effectively the spread of brucellosis by this means. The medical profession will do well to understand that there are no state laws in Ohio requiring pasteurization and that compulsory pasteurization is accomplished on a municipal or county basis. Stringent legislative measures and strict enforcement are essential to the success of widespread pasteurization. On the farm or small community where pasteurized milk is not available, raw milk may now be economically pasteurized at home or it can be boiled.

The prevention of brucellosis in those whose occupation necessitates frequent close contact with domestic animals remains very difficult and can be accomplished only by eternal vigilance in personal hygiene. There is no safe and dependable means of immunization in man. Certainly, the greatest possible protection for these workers would be the eradication of the animal reservoir of this disease.

CONCLUSIONS

1. The establishment of a diagnosis of brucellosis remains difficult and usually requires laboratory confirmation, the data from which must be carefully interpreted.

2. Aureomycin is the drug of choice in the treatment of acute brucellosis. Its value in the

treatment of chronic brucellosis remains to be determined.

3. Absolutely fundamental to the control of brucellosis in man is the eradication of the reservoir in domestic animals.

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Modern Trends in Radiology

Omissions in Medical Practice: (1) Failure to realize the importance of, and to carry out, a thorough clinical examination before any radiology—radiology being regarded as an easily obtained substitute requiring little personal effort. On the serious errors in diagnosis and treatment which this has occasioned, a great deal could be written. Careful attention to the clinical condition of the patients in these cases would have spared them much mental and physical pain, and the clinicians the blame the fruits of which they escape perhaps too often. There would be fewer errors in the interpretation of radiographs if radiology was always preceded by a sound clinical examination: if one of these must be omitted the least harm will come from omission of the radiography and most from omission of the clinical examination.

(2) There has been a failure to learn the bounds and appearances of the normal, and even the character of the artifacts produced by faulty material and techniques. Radiographic methods have been applied to the examination of structures made visible by contrast media, and operations have been conducted to remedy "defects" long before the appearance of the normal have been learnt (Ed. learned): when sound knowledge of the normal has with time and experience been acquired the operative measures for the correction of some of the "defects" have been abolished. This was very noticeable in the gastro-intestinal radiology. I am confident that in the realms of other specialties, notably thoracic surgary and neurosurgery, the same sequence will occur, for in these our knowledge of radiology, with and without contrast media, is still inadequate and incomplete; yet surgical explorations based upon the radiology are many.

(3) It is often not realized that the initial changes in many conditions are indistinguishable from one another, and that serial radiographs with continuous clinical examinations over a short or long period may be necessary for elucidating a problem.

(4) Many have failed to appreciate that the onset of disease is not associated with immediate changes in the radiographic appearances, and that it requires time—what I have called "the latent negative radiographic period," sometimes only a few days, but sometimes a year or more—before the changes are sufficient to produce enough contrast density or irregularity of contour to alter the radiographic appearances from the normal; by the time these changes are recognizable they are extensive—in some conditions more extensive than the radiographs suggest—in some cases healing may have commenced. Even fractures and other more serious conditions of bones and joints may be masked, if displacement has not resulted, until secondary changes have developed.

(5) There has been a failure to realize that, though the disease has ceased its activity, the radiograph may show spectacular appearances even to the end of an apparent normal life—the positive radiographic symptomless period. It is questionable whether surgical methods with their attendant risks would be so often undertaken if the full importance of this were understood. In some cases failure to appreciate omissions 4 and 5 have, on the other hand, led to the disregard of active clinical signs or recent injury when radiographs have shown no sign of change or only typical evidence of old healed lesions. You may ask what evidence I have of these omissions. I believe you could obtain such evidence from the activities in many hospitals, but the strongest evidence is in the boosting of mass radiography.—James F. Brailsford, M.D., British Medical Journal, No. 4630, October 1, 1949.

Early Recognition of Danger Signals During Anesthesia and Their Correction*

ROLLAND J. WHITACRE, M. D.

PROBABLY the most important factor in combating cardiorespiratory failure is recognizing the signs early and instituting the proper therapy promptly. This will greatly reduce the number of patients requiring heroic resuscitative measures. When acute emergencies occur, we often hear it said that the patient suddenly "went bad"—his circulation suddenly failed or he suddenly stopped breathing. As a matter of actual fact, what usually occurs is that it is suddenly discovered that the patient is in extremis. In the vast majority of cases, these sudden catastrophies are preceded by definite signs which give warning of the impending failure. The prompt institution of effective therapy at this time can often prevent serious cardiorespiratory depression.

Before discussing the early danger signals, I should like to mention a few precautionary or prophylactic measures which experience has shown to be of value.

The prophylactic use of intravenous fluids is now a common practice in preventing circulatory depression. We no longer wait for even the early signs of shock to appear before instituting supportive therapy. In most major operations, intravenous glucose is started routinely. In selected cases, such as intestinal resections or thoracic surgery, blood transfusions are started at the beginning of the operation.

Generally speaking, the experience and skill of the anesthesiologist are more important than the agent and technic used. Nevertheless, certain physical states in themselves make it unwise to use certain agents. Spinal anesthesia, for example, is a poor choice in the presence of shock or hemorrhage; cyclopropane is less likely to cause further depression. Pentothal should not be used in a patient with respiratory embarrassment.

The individual susceptibility of patients to predetermined doses of nonvolatile drugs must constantly be anticipated. Rapid induction with pentothal and curare, or a large dose of spinal anesthesia will, in some cases, lead to profound depression, Fatal cardiorespiratory depression has occurred from ordinary doses of all the commonly used agents.

OXYGENATION AND HYPOXIA

Having the proper resuscitative equipment readily available for the administration of oxygen is of the utmost importance. This applies to local and intravenous as well as to general anesthesia. It is amazing how often this elementary precaution is neglected, even in the best-equipped operating rooms. It is not sufficient to have the equipment in the next room or down the hall. Furthermore, it must be in good working order and ready for use.

Position on the operating table is another significant factor. Certain positions are more likely to precipitate circulatory and respiratory failure. In the sitting position the patient should be protected against the pooling of blood in the lower extremities. Peripheral vascular support by the use of elastic bandages or a G. suit is an effective measure in preventing dependent stagnation. The use of the prone position, particularly in obese individuals, or of the steep Trendelenburg position may cause marked respiratory depression. The real solution of these and many similar problems depends on the careful observation of the patient at all times. This is facilitated by keeping accurate records during the anesthesia.

Evidence of obstruction is one of the first indications of what is perhaps the most common cause of respiratory failure. In the past, when ether was the principal agent, obstruction was usually accompanied by noisy respiration and was therefore easily detected. Today the widespread use of depressing drugs such as pentothal or cyclopropane has complicated the problem of recognizing obstruction because the patient may not make sufficient respiratory effort to cause a noise. Quiet respiration should not be relied upon as an indication of an unobstructed airway.

Usually our problem is with upper respiratory tract obstruction, but interference with gas exchange in the lower bronchial tree is occasionally encountered. The latter is usually due to the presence of foreign material or to bronchospasm. Foreign material must be promptly re-

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moved. Bronchospasm is sometimes encountered during the administration of pentothal, curare, or cyclopropane and may be relieved by changing to sympathomimetic agents such as nitrous oxide or ether and oxygen. Isuprel hydrochloride, administered intravenously, has also been used with some success to alleviate this condition. The insertion of an endotracheal tube during too light anesthesia frequently causes severe bronchospasm. This can be avoided by making sure that an adequate depth of anesthesia has been reached before intubation.

Any alteration in the rate or depth of respiration should be carefully noted. A sharp increase in the rate of respiration or a decrease in the depth may interfere with adequate pulmonary ventilation and lead to hypoxia. A decrease in the minute volume exchange requires lightening of the anesthesia, administration of a higher concentration of oxygen, or inflation of the lungs. The important thing is to be aware that respiratory depression is occurring and to institute these measures promptly.

A progressive paralysis of the intercostal muscles is indicative of increasing depth of general anesthesia or a high level of spinal anesthesia. Unopposed action of the diaphragm may cause a tracheal tug to develop or a gasping type of respiration may occur. It is important to recognize that this denotes impending respiratory failure. At this point the exaggerated diaphragmatic activity may be pushing the intestines into the abdominal incision and hampering the work of the surgical team. This is often erroneously considered as evidence that deeper anesthesia is required. The proper treatment is, of course, to lighten the anesthesia, give oxygen, and allow a few minutes for the patient to eliminate the excess carbon dioxide that has accumulated during the period of inadequate ventilation.

The appearance of cyanosis should be considered a sign of inadequate oxygenation of the blood. It is equally important to recognize that a patient may be hypoxic without being cyanotic. An inadequate supply of circulating hemoglobin or a pallor due to peripheral vasoconstriction, which often accompanies circulatory depression, may completely eliminate cyanosis as a dependable clinical guide. It has been demonstrated that, even in normal patients, trained observers cannot always detect cyanosis until the arterial oxygen saturation is dangerously low.[1]

It is much easier to prevent hypoxia than it is to detect it, and preventing it can best be accomplished by administration of an excess of oxygen at all times. Maintenance of adequate oxygenation to the tissues, especially those of the heart and brain, is fundamental in the prevention of respiratory or circulatory depression during anesthesia.

CARDIOCIRCULATORY FAILURE

Perhaps the most reliable signs of circulatory failure are a decrease in blood pressure and an increase in the pulse rate. Both of these should be checked and recorded by the anesthesiologist at least every five minutes.

The use of cardiac and circulatory stimulants has a limited but nevertheless a very definite place in combating some of the early signs of cardiac failure. A fall in blood pressure with a marked decrease in pulse pressure that does not respond to reasonable replacement therapy, or the onset of auricular fibrillation or decompensation during anesthesia merit the consideration of administering ouabain, a drug that could be used to advantage much more frequently than it is at the present time.

Acute hypotension of reflex origin, which results from the use of gallbladder or kidney rests, may be benefited by small intravenous doses of ephedrine. Likewise, the sudden hypotension due to spinal anesthesia indicates the use of a vasoconstricting drug. In this connection, it should also be remembered that the elevation of the legs to right angles to the body is a prompt and effective method of decreasing the amount of blood pooled in the lower extremities.

It is usually recognized that an increase in pulse rate to 120 or more is indicative of the onset of surgical shock. But a slowing of the pulse to 60 or less may indicate a decrease in cardiac output and be equally significant. It may occur during spinal anesthesia, in which case it indicates that the level of anesthesia is ascending into the upper thoracic region and is paralyzing the cardiac accelerator fibers. This should warn the anesthesiologist of the possibility of further circulatory depression. During general anesthesia, an intravenous dose of atropine may be given to correct a bradycardia of vagal origin. In many long operations, particularly those in the thorax, undue vagal stimulation should be blocked by repeated doses of atropine if the heart rate is 60 or less.

Irregularities in the pulse rate should make one cautious against deepening the level of anesthesia.

A decrease in skin temperature accompanied by sweating has long been recognized as a sign of circulatory depression and may indicate the need for intravenous fluids or blood transfusions.

The cerebral effects of cardiorespiratory depression are, for the most part, related to oxygen deficiency. Disorientation, excitement, loss of consciousness, muscular twitchings, particularly those originating in the region of the head and neck, and generalized convulsions are very likely

to be followed by depression of respiration and circulation. Likewise, loss of the corneal reflex and dilation of the pupil should command careful evaluation.

REFLEX ACTIVITY

Reflex disturbances due to surgical manipulation may produce serious depression. Complications from this source can be guarded against by (1) adequate depth of general anesthesia to prevent reflex activity; (2) blocking the reflexes with some form of regional or local anesthesia; and (3) preventing hypoxia from occurring during these reflex manifestations—because in the presence of oxygen lack, fatal damage is much more likely to occur.

CONCLUSION

We have reason to be hopeful that, in the future, recognition of the early signs of cardiorespiratory depression will be facilitated by the application of better diagnostic instruments. The use of the oximeter will enable us to know the oxygen saturation of the blood at all times. The electrocardiograph and electroencephalograph, as well as equipment for continuous recording of the blood pressure and pulse, will provide much more reliable information as to what is happening to the patient during anesthesia. The recent development of an electronic spirometer for the constant measurement of breathing gives promise of being another step toward providing patients with better, safer, and more exact care during anesthesia.

At the present time, however, it is evident that the early signs of acute cardiorespiratory failure, though numerous, are not sharply defined. Their recognition requires meticulous observation of the patient at all times. No one sign can be relied upon to the exclusion of the others. Often the earliest indications are nothing more than subtle hints or isolated signposts which, in themselves, may have no clear-cut meaning. However, if each one is carefully noted and correlated with past experience, it may indicate a trend which will alert the anesthesiologist and surgeon to institute remedial measures and thus preclude more serious complications.

BIBLIOGRAPHY

1. Comroe, Julius H., Jr., and Botelho, Stella: The Unreliability of Cyanosis in the Recognition of Arterial Anoxemia. Am. J. Med. Sc., 214:1-6, July, 1947.

Duodenum—Because this first portion of the small intestine in man is about twelve inches in length, it was given the name duodenum which is derived from the Latin word duodeni meaning "twelve each."

* * *

Rectum—This last portion of the large intestine is so named because it is comparatively straight. The word rectum is derived from the Latin "rectus" or straight.

KEEPING UP WITH MEDICINE

• DIABETICS are especially prone to develop symptoms resulting from a deficiency of several fractions of the vitamin B-complex.

* * *

• WHEN we become sick it is because the unfavorable factors in our environment have caused our resistance to such factors to break down under the stress and strain of living with them. When we are ill with even relatively minor ailments, the ordinary worries of earning a living, taking care of our families and meeting our social and financial obligations all become more complicated and difficult to bear. They then aggravate our disease, and hinder our recovery by depressing our bodily functions.

* * *

• WITH the present low level of tuberculosis in this country, it does not seem likely that vaccination of the generally tuberculin-negative population with B. C. G. is a practical procedure.

* * *

• THE progressive development of the inhibitory process in the child represents an immunization and desensitization of his neuro-psychic constitution. It renders him refractory to his "neuro-psychic allergens."

* * *

• ONE of our greatest shortcomings is the incompleteness and haphazardness of our examinations of our patients' mouths.

* * *

• APPROXIMATELY 15 per cent of patients seen for vascular impairment due to arteriosclerosis give a history indicative of thrombosis of a major limb sometime during their illness.

* * *

• THE cytologic diagnosis of malignancy is moving forward at a very rapid rate.

* * *

• THE formation and growth of kidney stones lead all other pathological processes in the destruction of kidney tissue.

* * *

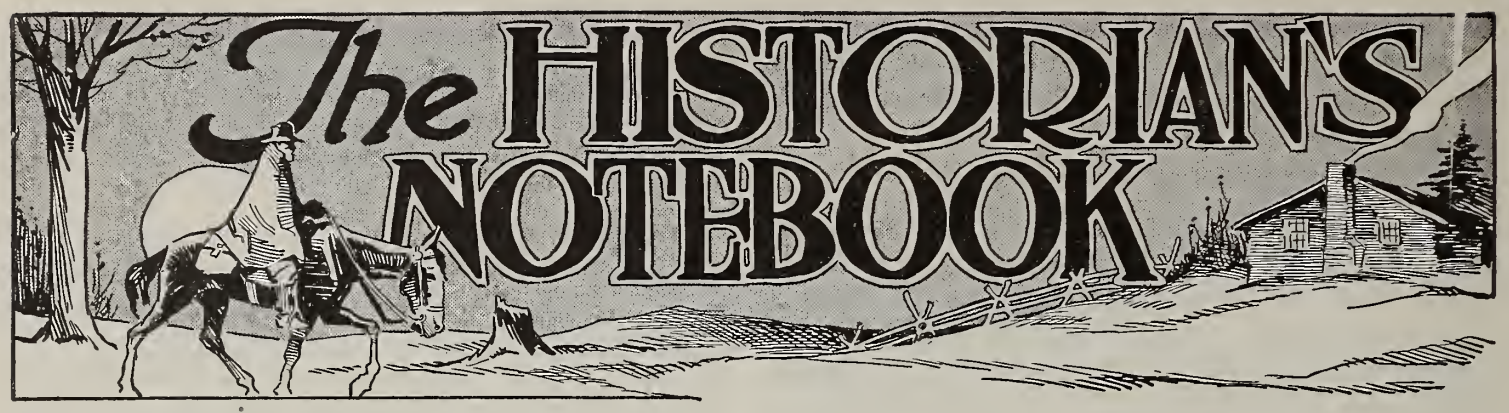
• AS yet, we do not have proof of any relationship between vitamin or protein deficiency and peptic ulcer in the human being. As a result of the ulcer, however, many patients are deficient in vitamins C, B, and proteins.

* * *

• NUMEROUS studies in many parts of the country made in the last few years have shown that all but a very few pregnant women have seriously inadequate diets.

* * *

• CHILDREN do not just grow up. Actually, growth is a far more complicated business. The shape and form of the body changes—and in several ways. The head, the arms and legs, and the other parts of the body grow at different rates.—J. F.



Ground Rules for Doctors of Morgan County in 1848

A CENTURY ago Morgan County had at least 18 practicing physicians, probably more, compared with the five who are now actively engaged in general practice and the two resident members of the staff of Rocky Glen Sanatorium. A copy of the "Constitution of the Morgan County Medical Society, together with Code of Ethics and Fee Bill" lists these 18 early doctors as well as much interesting data about medical practice 100 years ago. The time-worn pamphlet is in possession of Dr. C. E. Northrup and was found a number of years ago by his son, Dr. Edgar Northrup, now of Marietta. Five dollars was set as a fair fee for delivering a baby in 1848 and it was considered unethical by the society to "make gloomy and unfavorable prognostications, savoring of empiricism."

EIGHTEEN PHYSICIANS

The 18 members of the society are listed in the booklet as follows: P. B. Johnson, Charles Robertson, E. Dawes, John Hull, H. H. Little, W. F. Grubb, McConnelsville; H. C. Grimmell, J. G. Shoch, Malta; N. M. Nichols, Pennsville; U. K. Hurd, W. H. Reeves, Deavertown; James Bell, John S. Abbot, Windsor; J. C. Clark, Anderson's Store; A. Plumley, Meigs Creek; James Rusk, Triadelphia; and Daniel Rusk and H. Dover, Rosseau.

Dr. Charles R. Robertson was the author of the History of Morgan County bearing his name, the Robertson family home being the large frame structure on Fourth street which Andrew Wilson razed a number of years ago to make way for the building and lot now used by Bill Janes' Motor Sales. According to his autobiography, Dr. Robertson practiced in McConnelsville nearly 60 years and was born near Leesburg, Loudon County, Virginia. Poor, losing his mother at an early age, he took his first job as an apprentice printer in a time when wages for the craft were notoriously low, made the best of the meagre library of the editor of the St. Clairsville "Repository" and at the age of 21 became postmaster at St. Clairsville. With the aid of the salary and the spare time his job afforded him, he read medicine under Dr. W. Wood and in three years was licensed to practice. He first practiced in Barnesville, later in Woodsfield and came to McConnelsville in 1826, still keeping his hand in the printing trade by setting type and performing kindred jobs as a hobby in his spare time in the old *Morgan Sentinel.* Mrs. Dessie Robertson Barrows of San Jacinto, Calif., is his last surviving daughter.

From Dr. Robertson's history, we quote the following biographical data about the other physicians on the membership roster:

Dr. Perley Brown Johnson was among the first physicians who permanently located in the county and for many years was an influential and honored citizen. Dr. Johnson has more namesakes in Morgan County than any other man and perhaps more than all others who have lived here (Dr. Robertson notes). He was born in the block house at Marietta and read medicine under Dr. John Cotton, before locating in McConnelsville in 1823.

Edward Dawes—We have been unable to find any data on Dr. Dawes, other than that he was deceased when Dr. Robertson's history was compiled in 1886.

John Hull, H. H. Little, and William F. Grubb, M. D.'s, no data in Robertson, other than that Drs. Hull and Grubb were deceased at time of publication.

H. C. Grimmell and J. G. Shoch of Malta, likewise, no data, but are listed as deceased members of the Morgan County Medical Society, having been admitted in 1840 and 1842, respectively.

REEVES BROTHERS

N. M. Nichols, M. D., Pennsville, admitted to the society in '44; U. K. Hurd, M. D., Deavertown, admitted to society in '44, practiced at Deavertown for 19 years, leaving in '64. W. H. Reeves, M. D., Deavertown, admitted to the society in 1846. With his brother, Dr. James Reeves, Dr.

This historical feature article appeared in the January 26, 1950, issue of *The Morgan County Herald,* and is based on information obtained from C. E. Northrup, M. D., McConnelsville, and the document he possesses.

Reeves practiced for many years at Deavertown and was an ardent abolitionist while his brother, James, took the other side of the question. The story made famous by the late A. H. Humphries in his "The Underground Railroad" of the hiding of an escaped slave in the tyler's room of Doric lodge at Deavertown, gives an intimate glimpse into the life of the Drs. Reeves. Mr. Humphries relates how T. L. Gray met W. H. Reeves one evening and was told that if he ever needed a horse to assist some unfortunate "on his way to Can-a-day" that "you know where mine always is in the stable." On the particular occasion referred to, the underground conductors needed a horse, but got the wrong animal, taking the one of Dr. James Reeves instead of that of his brother. Dr. James Reeves was called out early the next morning on a confinement case and went hurriedly to the stable where he was enraged to find his horse sweat-stained, and tired. He openly charged that it had been stolen by the abolitionists and gave his opinion of the whole anti-slavery outfit as being very low, stooping to steal horses in addition to Negroes.

James Bell, M. D., admitted to the society in 1846. Dr. Bell practiced for several years in Windsor township, then moved to McConnelsville, where he remained a few years, then sold out to Dr. Brown. He was a graduate of the Ohio Medical College and was regarded as a capable physician. He went to Indiana and died in Terre Haute.

JOHN S. ABBOT, M. D.

John S. Abbot, M. D., admitted to the society in 1846. A native of Washington County, Dr. Abbot was educated in the common schools and came to Morgan County in 1840 and began the study of medicine under Dr. James H. Berry and finished under Dr. James Bell. He established himself in the practice of his profession in Stockport in 1846 and at the time of publication of the Morgan County History was the oldest living member of the County Medical Society, having served as president, vice-president and on the board of censors. A Democrat in politics, a Universalist in religious belief, he was a Mason. On April 22, 1847, Dr. Abbot married Miss Lucretia White and the following children were issue of their marriage: Henrietta, Henry, Louisa, Se, John Q., May Bell, Jesse R., Arthur (Art of Cleveland), and James B., who was drowned when six years old.

Dr. J. C. Clark, Anderson's Store, one of the most romantic figures ever to reside in Morgan County, was a native of Ireland, enjoyed a tremendous practice, enviable reputation and has been the subject of more ghost and buried treasure stories than most any other citizen of this part of Ohio. The late V. B. Walters of Reinersville, in his "Manchester Men, Events and Reflections," devotes considerable space to Dr. Clark and quotes the following as a sample of his poetry:

Yet not all the wealth that surrounds us so tempting,
Can wean my fond heart from the scenes of my youth,
For Erin looms up in my soul's warm affection
And thrills every chord to love, friendship and truth.

Dr. Clark built the magnificent brick home atop the knoll in Manchester which was for many years the J. F. Elliott home and of late years has been the property of G. F. Grassel of Cincinnati. One of the early Knights Templar in this section, Dr. Clark left numerous signs of the fraternity in his house which can be seen to this day. The late Dr. W. E. Radcliff of Caldwell, who once practiced in Reinersville, came into possession of the dagger and baldric which were part of Dr. Clark's Templar uniform and had planned, before his death, to present them to Cambridge Commandery, where he, himself, was a past eminent commander. Gold coins still turn up occasionally in the hog lots and under the sod at the Clark farm, supposedly tokens of the wealth accumulated by this early practitioner who had a deep-seated mistrust of banks and was purported to have buried untold wealth somewhere about his home.

Dr. Aaron Plumley, Meigs Creek, admitted to the society in 1846.

DANIEL RUSK, M. D.

Jas. Rusk, M. D., Triadelphia, admitted to society in '42 and Daniel Rusk, Rosseau, admitted to the society in 1847. Dr. Robertson lists Dr. James Rusk as a deceased member of the society and gives no biography, but devotes considerable space to Dr. Daniel Rusk, the father of James M. Rusk, former editor of the *Herald*, and the grandfather of Dr. Rogers D. Rusk of Mt. Holyoke, Mass. Dr. Rusk farmed and taught school for a number of years until turning to the medical profession. As a student in medicine, he gained fame for his success in treating typhoid fever when other physicians failed in many cases during an epidemic and saved the life of his brother, Jeremiah, who was later to become Governor of Wisconsin and second Secretary of Agriculture. Dr. Rusk read medicine three years with his brother, James, then spent two years with Dr. James Reeves of Deavertown. In the fall of 1847, he moved to Rosseau, living there until the death of his wife in 1858. He then with his two boys, James M. Rusk and W. A. Rusk, moved to Malta. He was appointed U. S. examining surgeon for Morgan County in 1875, continuing in office until 1885.

Hiram Dover, Rosseau, admitted to the society in 1846.

FEE BILL

The Fee Bill of the society is interesting as will be noted from just a few of the items

quoted. For a visit in town (not more than two to be charged in the same day), 75c. For a prescription to a drug store, 20c to $1. Amputations of the arm, tibia and fibula were from $15 to $25 and of the femur (hip bone), $25 to $50. If it were only a finger or a toe, the physician could let you off with $2.00 to $5.00. If unfortunate enough to be born with a hair lip, you could have same fixed for $10 to $25 and ordinary obstetrical cases were $5, except that if prolonged the doctor could charge the parents $1 for every 12 hours extra he had to wait on your arrival.

Finally, the society strictly charges its members that: "The use of nostrums and quack medicines should be discouraged as degrading to the profession, injurious to health, and often destructive to life. Patients, however, under lingering disorders, are often determined on having recourse to such as they see advertised, or hear recommended with a boldness and confidence which no intelligent physician dares to adopt, with respect to the means that he prescribes. In these cases some indulgence may be accorded to a credulity that is insurmountable and the patient should neither incur the displeasure of the physician or be entirely deserted by him; but it is the duty of the attending physician to warn them of the fallacy of their expectations, of the danger of the experiment, and the necessity of strict attention to the effects produced by them in order that their bad effects, if any, should be timely obviated."

Dr. Lester E. Siemon, of Cleveland, 1867-1943

Dr. Thomas A. McCann, of Dayton 1858-1943

Two pioneers passed away in 1943 that may well be considered together and whose counterparts, a century might not produce in Homeopathy or in any other school of medicine. They were contemporaries and intimate friends, Drs. Tom McCann of Dayton and Lester Siemon of Cleveland. Each served on the Ohio State Examining Board with great credit to our school of medicine. Dr. Siemon from the year 1911 served several terms and was even president of the Board for a time, and Dr. McCann served sixteen years and as I remember it, they were on the Board together for ten years.

Both of these men had unusual, outstanding gifts which they used unstintedly in the interest of Homeopathy and of all medicine and in any position of trust wherever it might be. They never jockeyed for position and power. Both had large practices, and held the deep regard and confidence of their communities.

Among other things which they held so strangely in common, both men were ardent hunters and fishermen, lovers of nature, who yearly sought the wilds of Canada for mental and physical solace. Both were intensely human, Democrats and of Irish descent. Both were deeply religious; one a Baptist, the other of Quaker ancestry, and were high in Masonry. Both were outstanding after-dinner speakers, or at any other time and place without previous preparation. Both were adept at unstuffing the stuffed shirt, and both fought valiantly for a righteous cause. No one ever had to wonder how they stood, they told you. Above all things they had courage, "that lovely virtue, the rib of Himself, which God sent down to his children."

Because they so richly deserved them and had earned the honors thrust upon them, each had held practically every position in the gift of the homeopathic school, state, national, international and local, with honor and distinction.—Lucy S. Hertzog, M. D., Chardon, Ohio.

Dr. Hamilton Fiske Biggar, 1839-1926

Dr. Hamilton Fiske Biggar was born in Toronto in 1839, and died at the age of 89 in 1926. He was the son of a Methodist circuit rider. At the age of twelve he found and read a copy of the *Cleveland Plain Dealer* and decided at once upon Cleveland as his objective along with the profession of medicine. He made both objectives. He graduated from Victoria University, came to Cleveland and graduated a good homeopath from the Cleveland University of Medicine and Surgery in 1866.

By 1880 he had become prominent as one of the most successful surgeons and gynecologists in Cleveland, and a splendid leader and teacher who became nationally known. His many great gifts and characteristics inclined him to be an autocrat and a storm center. His Thursday afternoon clinics were the high point of the week's work to students, because of his clear teaching and gracious handling of patients. He held an audience by sheer charm and humorous narrative of fact and experience. He was a man of education and culture, extraordinarily resourceful in the care of his patients, and never gave up until the grim reaper took over. He was well known as J. D. Rockefeller's personal physician.

Dr. Biggar had the grand manner—an air of distinction which easily made him the most impressive figure in any audience. Consciously or unconsciously he dominated any gathering of the medical profession and he was equally acclaimed for his ability by all schools of medicine. "Age did not wither nor custom stale his infinite variety."—Lucy S. Hertzog, M. D., Chardon, Ohio.



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for the

1950 Annual Meeting

Ohio State Medical Association

Cleveland, Ohio . . . May 16, 17, 18

NAME AND LOCATION	SINGLE	DOUBLE	DOUBLE TWIN BED
ALLERTON HOTEL, 1802 E. 13th St.	$3.50-6.50	$5.50-10.00	$6.00-10.00
AUDITORIUM HOTEL, 1315 E. Sixth St.	$3.50-3.75 $4.50-5.00	$5.50-6.00 $7.00	$7.50 and Up
CARTER HOTEL, PUBLIC SQUARE	$4.75-7.00	$7.00-10.00	$8.00-12.00
CLEVELAND HOTEL (Headquarters Hotel)	$4.50	$6.50-9.00	$9.00-14.00
HOLLENDEN HOTEL, 610 Superior Ave.	$3.50-8.00	$5.50-10.00	$7.00-14.00
OLMSTEAD HOTEL, Superior & E. Ninth	$3.00-6.00	$5.00-8.00 $7.00-9.50	$7.00-9.50
STATLER HOTEL, Euclid at E. 12th St.	$4.00-6.00	$7.00-10.00	$8.00-12.00

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Mail the coupon to hotel selected

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You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 16, 17, 18, 1950, or for such other period as may be indicated herein.

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☐ Twin Bed Room with Bath ☐ Suite

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May 16, 17 and 18

OHIO STATE MEDICAL ASSOCIATION

ANNUAL MEETING

CLEVELAND, OHIO

Here Is Ohio's Most Comprehensive Medical Program of the Year, Condensed Into Three Days of Conveniently Arranged Schedules

Scientific Program Begins 1:00 P.M. Tuesday—Ends 3:45 P.M. Thursday

All Schedules, Daylight Savings Time

Fourteen Instructional Courses . . . Scientific Programs by Specialty Sections for Doctors in All Branches of Medicine . . . **Scientific, Educational and Technical Exhibits . . .** Banquet With Entertainment and Dancing . . . **Addresses on National Affairs by The Honorable Robert A. Taft and Dr. George F. Lull . . .** Fraternal and Class Reunions . . . **Medical Topics of the Day . . .** Program and Entertainment for Ladies by the Woman's Auxiliary . . . **Sessions of the House of Delegates.**

For Summary See Facing Page
For Complete Details See April Issue of THE JOURNAL

Summary of 1950 Annual Meeting Program

Time Shown Is Daylight Savings Time

★

TUESDAY, MAY 16

10:00-12:00 Noon—House of Delegates Business Session and Luncheon

1:00- 2:30 P.M.—Medical Topics of the Day:
"Risk Factors in Anesthesia," R. J. Whitacre, M.D., Cleveland, Moderator
"Nephritis and Nephrosis," J. M. Hayman, Jr., M.D., Cleveland, Moderator
"Neuroses and Early Psychoses in General Practice," Calvin L. Baker, M.D., Columbus, Moderator

2:30- 3:00 P.M.—Recess for Visiting the Exhibits

3:00- 5:25 P.M.—General Session:
"Psychiatry in General Practice," Maurice Levine, M.D., Cincinnati
"Present-Day Practice in Obstetric Analgesia," George J. Andros, M.D., Ann Arbor, Mich.
"Modern Concepts of Anesthetic Management for Gynecological and Obstetrical Patients," Ralph M. Tovell, M.D., Hartford, Conn.
"Resuscitation of the Newborn," J. J. Jacoby, M.D., Columbus

7:30 P.M.—Annual Meeting of the Ohio Academy of General Practice

WEDNESDAY, MAY 17

9:00-10:30 A.M.—Instructional Courses Nos. 1, 2, 3, 4, 5

9:00-12:00 Noon—Annual Meeting of the Ohio State Radiological Society

10:30-12:00 Noon—General Session:
"Progress in Medical Care," The Honorable Robert A. Taft, of Ohio, Member of U.S. Senate
"Your A.M.A. and Its Activities," George F. Lull, M.D., Chicago, Ill.

12:00 Noon—Luncheon Meeting of Ohio Chapter of the American College of Chest Physicians

1:00- 2:30 P.M.—Medical Topics of the Day:
"Convulsive Disorders: Recognition and Treatment," Max T. Schnitker, M.D., Toledo
"Peripheral Vascular Disorders," William D. Holden, M.D., Cleveland
"Retroperitoneal Tumors," William J. Engel, M.D., Cleveland

2:30- 3:00 P.M.—Recess for Visiting the Exhibits

3:00- 5:30 P.M.—General Session:
"Diabetic Ketosis," Cecil Striker, M.D., Cincinnati
"Urinary Bladder Emergencies," Eugene A. Ockuly, M.D., Toledo
"Immediate Management of Head Injuries," Joseph P. Evans, M.D., Cincinnati
"Full-Scale X-Ray Chest Examinations," Fred J. Hodges, M.D., Ann Arbor, Mich.
"Metabolic Effects in Man of ACTH and Cortisone (Compound E)," Jerome W. Conn, M.D., Ann Arbor, Mich.

7:30 P.M.—Annual Banquet—Entertainment—Dancing

THURSDAY, MAY 18

9:00-10:30 A.M.—Instructional Courses Nos. 6, 7, 8, 9, 10

10:30-12:00 Noon—Instructional Courses Nos. 11, 12, 13, 14

12:00 Noon—Luncheon and Business Session of House of Delegates:

1:30- 3:45 P.M.—General Session:
"Prevention and Treatment of Deafness in Children," Harry C. Rosenberger, M.D., Cleveland
"Early Recognition of Visual Defects in Children," Lorand V. Johnson, M.D., Cleveland
"The Primary Tuberculous Complex: Some Clinical and Roentgenographic Features," John Caffey, M.D., New York, N.Y.
"Review of Acute Upper Respiratory Diseases," John H. Dingle, M.D., Cleveland

Commission on Children . . .

State and Local Organizations Are Paving Way for Participation in 1950 White House Conference; Doctors Are Taking Prominent Parts

THE Ohio Commission on Children and Youth, assisted by committees in most of the counties, is paving the way for the Midcentury White House Conference on Children and Youth to be held in Washington during December.

The Commission, appointed by Governor Frank J. Lausche in May of 1949, is conducting fact-finding studies of children and youths in their different environments—at home, at church, at school, at work, etc.

County committees are representative of parents, clubs, churches, unions, fraternities, professions, and public and private organizations that have concern for children. They are gathering data, promoting discussions of child and youth needs in their own areas and will serve as spearheads for local activity following the White House Conference.

MEDICAL PROFESSION'S PART

The Council of the Ohio State Medical Association at a recent meeting recommended that County Medical Societies have representation on these county committees in order that members of the medical profession might properly advise and guide on matters pertaining especially to medical care and health.

Dr. Carl A. Lincke, Carrollton, President of the Association, is its official representative on the Commission by invitation of the Governor. Dr. Lincke has pointed out that participation of doctors in these local projects provides another means through which the medical profession can make a positive contribution to community betterment. Physicians who have not already done so are invited to contact their local committees and offer their services.

J. Gordon Crowe, executive secretary of the Commission, said that to the best of his knowledge the medical profession is represented on every county committee thus far organized. All but about six of the counties had been organized early in April, Mr. Crowe revealed, adding that he believed all 88 would be organized before June.

Serving on the Executive Committee of the Commission are three Ohio physicians: Dr. James D. Kramer, Akron, chairman of the Ohio State Medical Association's Committee on Public Relations and Economics; Dr. Thomas E. Shaffer, Columbus, chairman of the Association's Committee on School Health; and Dr. John D. Porterfield, director of the Ohio Department of Public Health. Herschel W. Nisonger, Ph. D., recently succeeded the late Judge Raymond P. Smith as chairman of the Commission. Dr. Nisonger is director of the Bureau of Special and Adult Education at Ohio State University. Offices are maintained at 303 State Office Building, Columbus.

HISTORY OF COMMISSION

The history of the White House Conferences goes back four decades. Since 1909, a conference has been called every ten years by the President of the United States to consider the needs of children and youth throughout the Nation. In January, 1948, the National Commission urged that special attention be given the 1950 White House Conference through intensive advance study by the individual states. This special attention was urged because of the tremendous impact of World War II upon the lives of young people, and because of new knowledge about their needs and how to meet them.

In response to this proposal, the United States Children's Bureau called a conference of states' representatives who met in Washington early in 1948. Later in that same year, upon invitation of the incumbent Governor, Thomas J. Herbert, a group met to hear reports of Ohioans who attended the Washington Conference. The group voted to recommend to the Governor creation of the Ohio Commission.

OHIO GROUP ORGANIZED

In May, 1949, 80 representative citizens, invited by Governor Lausche, met and organized. It was decided that the commission should consist of all original invitees to the meeting (125) who cared to serve. The commission also voted to have an executive committee, to include a chairman, appointed by the Governor, 17 members elected by the commission, and the directors of the Education, Health, Industrial Relations and Welfare Departments.

COMMITTEES HIGHLIGHT OBJECTIVES

In order to carry out its objectives and program the commission has set up major committees.

The Committee on Children and Youth at Home is concerned with all aspects of home life and the factors which affect them. Subcommittees deal with physical and mental health, economic security, housing, welfare services and spiritual needs. Parent education is a major consideration.

Committee on Children and Youth Away From Their Homes is studying programs and facil-

ities for children who reside in other than their natural homes.

Committee on Children and Youth at School compares findings on education in Ohio with generally accepted standards.

Committee on Children and Youth Out-of-School is studying civic, vocational guidance, job placement, employment, education and recreational opportunities and needs of youth from 16 to 25.

Committee on Children and Youth at Work is attempting to determine adequacy of present child labor laws and their enforcement; make special studies of agricultural and hazardous occupations and study general work experience in its relationship to education.

Committee on Children and Youth in the Community is concerned with recreation, intercultural relations, law enforcement, community services, and community planning and coordination.

Committee on Children and Youth and the Church is studying the role that the church is playing in the lives of youth especially in strengthening family life.

In addition there are three committees which have to do with administration and organization. They are the Committee on Research and Fact-Finding, the Committee on Community Organization and the Committee on Publicity and Public Relations.

Two physicians head important subcommittees. Dr. Benjamin Hoyer, Cincinnati, is chairman of the Committee on Health Services for Children, a subcommittee of the Committee on Children and Youth in the Community. Dr. Margot Deckert, Columbus, is chairman of the Committee on Physical Health, a subcommittee of the Committee on Children and Youth at Home.

County Committees do not necessarily follow the organization pattern of the state Commission. Each county committee sets up its own organization according to local needs.

An important phase of the work is that youths from 15 to 25 are being invited to take part in all conferences from the county level to the White House Conference.

Physicians Needed in Pacific

On July 1, 1950, the administrative responsibility for Guam and American Samoa, which are U. S. possessions, and for the Trust Territory of the Pacific Islands, which comprises the former Japanese mandated Marshall, Caroline, and Marianas Islands, will be transferred from the Navy Department to the Department of the Interior. Plans are under way to replace Naval personnel, including physicians, with civilian personnel. Doctors interested should write the Divisions of Territories and Island Possessions, Department of the Interior, Washington 25, D. C.

New Specimen Container Used By State Laboratory

The Division of Laboratories of the Ohio Department of Health announced a new and improved type of feces container which is available to local health departments for use by private physicians as well as by public health or hospital physicians and nurses, according to an article in *Ohio's Health*.

The new container is for sending stool specimens to the Laboratory for culture on typhoid and Salmonella infections and bacillary dysentery. The outfit contains buffered glycerol as a preservative, replacing the sterile cotton swab used heretofore. According to Leo Ey, director of the Laboratory, stocks of old type mailing containers for feces may be returned to the Laboratory by health departments in exchange for the new.

It is anticipated that some of the more fastidious Salmonella and Shigella organisms will remain viable in the preservative, leading to greater chances for positive findings.

The Division of Laboratories desires also to function as a reference center within the state to which enteric cultures may be referred by other public health, hospital, or private laboratories for confirmation or identification.

Physicians and health department personnel are urged to make use of these culture facilities in detecting the causative agent of enteric infections. However, the routine culturing of stools of all food handlers in a community is not recommended. Such studies should be confined to those at whom the finger of suspicion points through epidemiologic investigation of existing cases of enteric infection.

In the use of the new specimen container, it is requested that a feces sample the size of a marble be added to the liquid in the specimen jar for culture. The same jar may be used for ova and parasite examinations, but the liquid should be poured out before adding the feces and a notation "For Parasites" should be added on the case history blank.

It is quite probable that a greater incidence of Salmonellosis and Shigellosis exists than is suspected on the basis of past laboratory findings. It is realized that, because of the time-consuming procedures, it may require several days before a suspicious organism may be properly identified by the Laboratory. Thus the report may be delayed for use by the physician in treating the patient. However, the epidemiologic and public health significance of positive findings should be obvious. More widespread infection may thus be prevented, the report states.

ARE YOU AND MEMBERS OF YOUR FAMILY REGISTERED TO VOTE?

New Program for Feeble-Minded . . .

Welfare Department in May Will Put Into Effect Revised Procedure For Reception, Classification and Custody of Mentally Deficient

AN executive order issued recently by Judge John H. Lamneck, director of the Ohio Department of Public Welfare, revises the procedure for care of feeble-minded persons accepted by the Department.

The executive order, scheduled to be put into effect early in May, was issued upon recommendation of Dr. Calvin L. Baker, commissioner of mental hygiene, with the approval of the Advisory Council to the Division of Mental Hygiene. It also has the approval of the Probate Judges Executive Committtee and the Executive Committee of the Ohio Mental Hygiene Association.

The order states that all feeble-minded persons committed to and accepted for care and custody by the Department of Public Welfare shall be maintained, treated and trained until discharged, released or placed as provided by law under a procedure which is outlined in the following paragraphs.

The institutions now designated as the "Columbus State School," the "Apple Creek State Hospital," and the "Gallipolis State Institute" will continue to be known by those names. The institution now designated the "Orient State School" will be known as the "Orient State Institute."

CARE OF EPILEPTICS

The executive order states that medical science has developed new methods of treatment of convulsive disorders which obviates the necessity for maintaining a separate institution in this state for the treatment and custodial care of patients with convulsive disorders who are not psychotic or feeble-minded. Hereafter psychotic patients with convulsive disorders who require institutional care and treatment will be committed and received at state hospitals other than receiving hospitals as mentally ill patients.

Feeble-minded persons with convulsive disorders who require institutional care and treatment will be committed and received as feeble-minded patients.

Patients with convulsive disorders who are not psychotic or feeble-minded and who require institutional care and treatment will be committed to and received at such institutions as the commissioner of mental hygiene may designate in each case.

Dr. Baker explained that patients with convulsive disorders after being classified as feeble-minded and needing custodial care will be transferred to Gallipolis. Under the former procedure virtually all patients classified as "epileptics" were committed directly to Gallipolis.

COLUMBUS STATE SCHOOL

The Columbus State School will be used for:

(1) The reception of all feeble-minded persons committed to the care and custody of the State Department of Public Welfare;

(2) The examination, observation and classification of all feeble-minded persons committed to the custody of the Department;

(3) The retention, maintenance, training and education of such feeble-minded persons committed to and received by the school as are capable of being trained and educated so as to render them more comfortable, happy and less burdensome to society, until released or discharged as provided by law.

ORIENT

The Orient State Institute will be used for the care and maintenance of such feeble-minded persons committed as may be ordered transferred to the institution from the Columbus State School on the order of the commissioner, or from other state institutions under the jurisdiction of other Divisions of the Department on order of the director of the Department.

APPLE CREEK

The Apple Creek State Hospital will continue to be used for feeble-minded persons who primarily need custodial care.

GALLIPOLIS

The Gallipolis State Institute will be used for the care and maintenance of such feeble-minded persons as may be ordered transferred there from the Columbus State School on order of the commissioner of mental hygiene, or from other state institutions under jurisdiction of other divisions of the Departments on order of the director. Patients will consist primarily of the feeble-minded with convulsive disorders.

STAFFS

There will be maintained at the Columbus State School, four principal staffs—medical, psychological, teaching and social service, with such auxiliary services as the commissioner of mental hygiene may deem necessary.

Medical Staff—The medical staff, under the superintendent, will be headed by a clinical director. To the extent that the Ohio State University College of Medicine is willing to par-

ticipate, the medical staff will be correlated with the staff of the College and with the staffs of other medical schools and hospitals of the State as desire to participate.

There also will be maintained at the Columbus State School a consultation staff, expert in the field of psychiatry and associated fields, drawn from the teaching staff of the Ohio State University College of Medicine, if the medical college is willing to participate, and other medical schools willing to participate. It also will formulate and establish research projects pertinent to mentally deficient persons.

Psychological Staff—The psychological staff will be headed by a chief psychologist and will plan, supervise, teach and evaluate results of psychological testing of feeble-minded persons. It also will formulate and establish proper research projects.

Teaching Staff—The teaching staff at the school will be headed by a superintendent of schools who will cooperate with the other staffs in the school in establishing proper courses for teachable wards and will supervise teachers and teacher-training programs. The superintendent of schools will cooperate with the director of the Bureau of Special and Adult Education of Ohio State University.

The Social Service Staff—The social service staff will be organized in conjunction with the school of any accredited college or university that may desire to participate. It will perform four major services as follows: (1) Pre-admission social service work; (2) hospitalization social service work; (3) home and community placement work; and (4) such work in the field of research as may be desirable.

ADMISSIONS TO COLUMBUS STATE SCHOOL

Admissions to the Columbus State School will be limited to commitments made by probate courts and to transfers from other state institutions. A classification staff is composed of the clinical director, all medical personnel on duty, the chief psychologist, the chief social worker, the superintendent of schools and certain other persons from the staffs. The classification staff will meet at stated occasions to determine whether each ward is a long-time custodial case and if so whether he requires maximum or minimum security; whether treatment or schooling or both will benefit a ward and if so what plan of education or treatment would be best suited; what disposition should be made of each ward.

There are also provisions for the superintendent, upon recommendation of the classification staff, to reëvaluate those under training; pass upon the fitness of each ward to be allowed to work outside the school or be granted trial visit, or be placed in a facility or home outside the school; recommend trial visits and discharges from the rolls of the school of all those who may be released with safety and who have received maximum training provided.

Upon the recommendation of the superintendent of the Columbus State School, the commissioner of mental hygiene is authorized to discharge such wards as he may deem advisable.

QUOTAS FOR ADMISSION

All feeble-minded persons requiring institutional care will be committed to the Columbus State School. Until further orders are issued, plans are to receive at least 75 feeble-minded persons per month committed by the various probate courts of the State if requests for admission should equal or exceed that number.

A quota system has been worked out whereby each county will be entitled to convey its proportion of persons received.

Ohio Tuberculosis-Health Assn. To Meet June 1-2 in Columbus

The Ohio Tuberculosis and Health Association will hold its 32nd annual meeting at the Neil House, Columbus, June 1 and 2. Dr. Azel Ames, Jr., Hamilton, president of the Association, will preside.

The two-day program will center around the voluntary health agency and ways and means by which it can stimulate the provision of better public health service in the county and state.

Dr. Thomas D. Dublin, executive director of the National Health Council, will speak on June 1 and will lead a session on the formation and use of community health councils.

At the annual meeting of the Board of Directors, Dr. Robert Bloch, Professor of Medicine, University of Chicago, will speak on "Tuberculosis in General Hospitals."

The featured speaker at the noon luncheon on June 2 will be Gerald G. Gross, editor of the "Washington Report on the Medical Sciences." Mr. Gross is well known in medical circles and is thoroughly familiar with the legislative aspects of public health.

Dr. Joseph B. Stocklen, Cleveland, is first vice-president of the Association, and Dr. Charles A. Doan, Columbus, is secretary. The Executive Committee includes Drs. Lynne E. Baker, Dayton; David W. Heusinkveld, Cincinnati; and Raymond C. McKay, Cleveland. Dr. John D. Porterfield, Columbus, is a member ex officio, and Dr. John H. Skavlem, Cincinnati, is a director-at-large on the board of the National Tuberculosis Association.

ARE YOU REGISTERED TO VOTE?
IF NOT, ACT PROMPTLY

Auxiliary Conference . . .

Officers and Committee Members of State and Local Units Guests at Columbus Meeting Where National and State Problems Were Discussed

"HOW Can Members of the Woman's Auxiliaries Help on Legislative Affairs and Public Relations?" was the theme of a conference held in Columbus on March 14 at which key officers and committee chairmen of County and State Auxiliaries were guests of the Ohio State Medical Association.

More than a hundred women attended the meeting and heard discussions on problems and goals common to Medical Societies and Auxiliaries. As the theme indicates, those present were given up-to-date information on what is taking place in Washington and other legislative fronts and on the educational program of the medical profession. The meeting was held in the Fort Hayes Hotel where luncheon was served in the Gold Room.

Dr. Carl A. Lincke, Carrollton, President of the Ohio State Medical Association, was chairman of the conference and welcomed visiting Auxiliary members. In an address entitled "We Want Your Help," Dr. Lincke outlined the threefold purpose of the meeting: (1) To offer some suggestions as to how the local auxiliaries and local medical societies can work together; (2) to get suggestions from Auxiliary members; and (3) to give key persons of the Auxiliary some up-to-date information on current state and national problems.

GOALS FOR 1950

Mrs. C. W. Kirkland of Bellaire, President of the Woman's Auxiliary to the Ohio State Medical Association, spoke on the subject, "Our Goals for 1950." The principal goal, she said, might be summarized as that of training women in the responsibilities of citizenship. She compared the indifference of Americans toward aggressive citizenship to that which prevailed in other countries which are now dominated by totalitarian governments.

"Where Do We Go From Here on Public Relations?" was the topic of a talk by Mr. George H. Saville, Director of the Department of Public Relations of the Ohio State Medical Association. Mr. Saville gave a comprehensive review of the public relations program of the A. M. A. and the Ohio State Medical Association—what has been done, and what is being planned for the future. He stressed the point that the heart of any public relations program for the medical profession must eventually go back to the individual doctor.

ARE YOU AND MEMBERS OF YOUR FAMILY REGISTERED TO VOTE?

P. R. PROPOSALS

The public relations chairman for the State organization of the Woman's Auxiliary, Mrs. Farrell T. Gallagher, of Cleveland, spoke on the subject, "Practical Public Relations Proposals." Mrs. Gallagher reminded her hearers that the Auxiliary has been called "organized medicine's great untapped resource." She gave a comprehensive summary of what has been done among the Auxiliaries in public relations, especially in contacts with other organizations, establishment of speakers' bureaus, and the like. A review of successful public relations projects of Auxiliaries and suggestions for the future formed a prominent part of her talk.

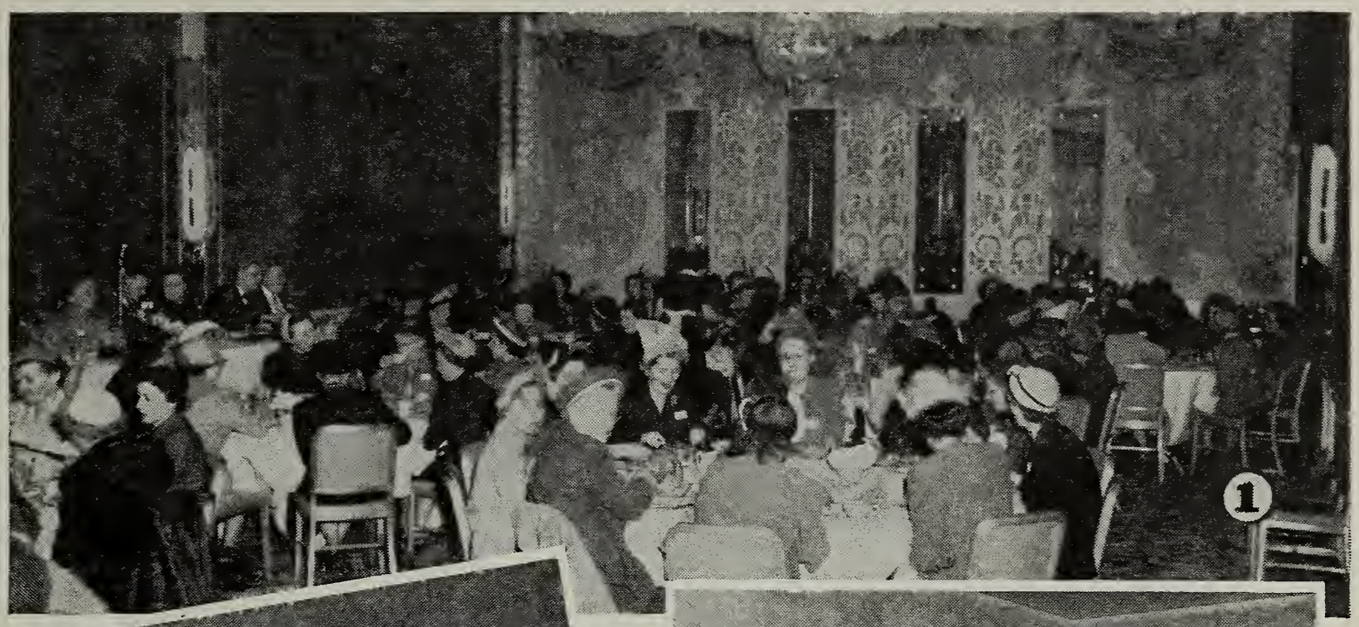
See Pictures on Facing Page

Mr. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, addressed the group on the subject, "What's New in Washington?" After a review of highlight medical and health bills in Congress, Mr. Nelson reminded the audience that regardless of what takes place in Congress, medical and health issues will be discussed more in the coming congressional campaigns than ever before. He then explained the workings of the Association's Legislative Committee and County Legislative Committees, whose members evaluate candidates for public office as to their qualifications, especially in regard to their stand on health and medical matters regardless of party affiliation, and attempt to interest doctors in the campaigns. Mr. Nelson concluded his remarks by saying that "no valid reason can be advanced against the legal participation by individual physicians and medical societies anywhere in political activities, providing the medical profession everywhere, collectively and individually, at the same time (1) offers a positive, constructive, workable health program; (2) cooperates with other dependable groups in efforts to solve existing health problems; (3) makes every possible effort to supply the people of all communities with medical services which are adequate in quality and in quantity; and (4) actively supports those medical and health proposals which are sound and desirable."

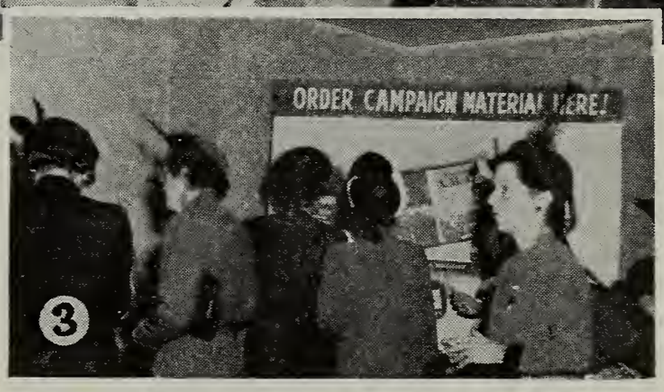
'LET'S DO IT'

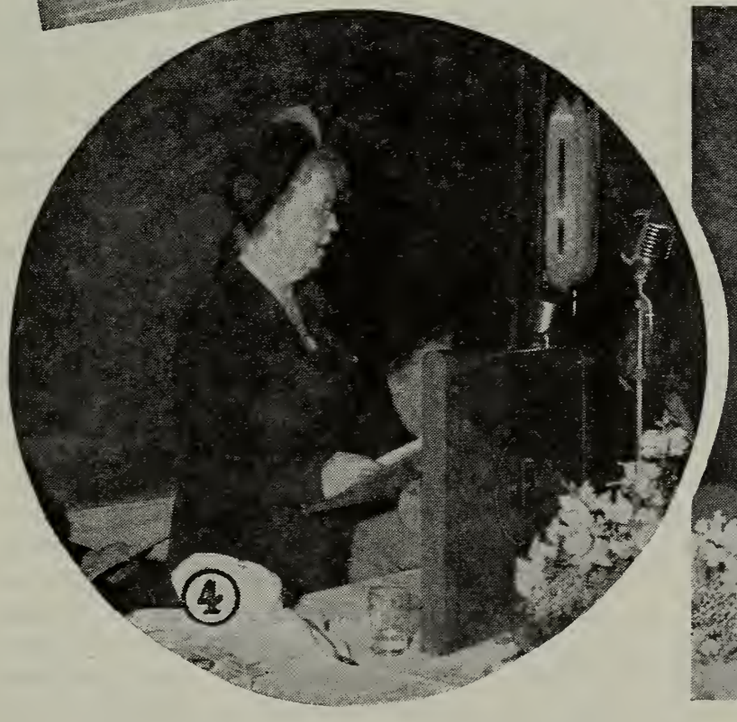
Dr. E. O. Swartz, Cincinnati, President-Elect of the Ohio State Medical Association, gave a stimulating talk on the subject, "We've Got a Job To

Ladies Hear and Discuss Public Relations











O. S. M. A. Staff Photos

1. More than 100 key officers and committee chairmen of Woman's Auxiliaries are shown as they enjoyed luncheon and discussed problems common to Medical Societies and Auxiliaries, as guests of the Ohio State Medical Association.

2. Three of those at the speakers' table are shown. They are Dr. E. O. Swartz (left), Mrs. C. W. Kirkland and Dr. Carl A. Lincke.

3. Educational material for distribution was available at the meeting and is always available through the Columbus Headquarters Office.

4. Mrs. Kirkland, president of the Auxiliary, is shown as she addressed the group.

5. Mrs. Farrell Gallagher, chairman of the Auxiliary Committee on Public Relations, was one of the principal speakers.

For details, see facing page

Do; Let's Do It." Characterizing this as the most critical year for medicine in our generation, Dr. Swartz declared that "we must be partisan to the extent that we support those who take our part in the struggle." He reminded his hearers, however, that the only way to get public support is through public service.

Dr. Lincke introduced the following other persons seated at the speakers' table: Mrs. George Cooperrider, Columbus, president-elect of the Auxiliary; Mrs. E. Benjamin Gillette, Toledo, past-president; and members of the advisory committee of the Ohio State Medical Association to the Auxiliary—Dr. Harve M. Clodfelter, Columbus, chairman; Dr. Paul A. Davis, Akron; and Dr. Chester P. Swett, Lancaster.

The program was concluded with a general discussion. A wire recording of the conference was made. A brochure will be prepared later for general distribution.

Ohio Trudeau Society Is Formed; To Meet June 1 in Columbus

A group of interested physicians have formed an Ohio Section of the American Trudeau Society. The decision to form this section grew out of a desire on the part of lay workers in the tuberculosis field and physicians interested in tuberculosis and allied chest diseases to work together in greater harmony through a better understanding of the problems of each.

The first meeting of the group was held May 19, 1949, at the Neil House in Columbus. It was decided that the Ohio Section should be formed and that the American Trudeau Society should be petitioned for permission to so form.

Dr. John A. Prior, Ohio State University, Columbus, was elected temporary chairman. A petition was drawn up, signed, and forwarded to the American Trudeau Society. Charter members signing the petition include Drs. Joseph B. Stocklen, Cleveland; Harold G. Curtis, Warrensville; Elsa Klein, Chillicothe; Karl P. Klassen, Columbus; D. E. Wetterauer, Columbus; Max L. Durfee, Oxford; Frederic M. Howard, Toledo; Maurice G. Buckles, Columbus; Casper H. Benson, Columbus; David W. Heusinkveld, Cincinnati; Edward Arnold, Canton; Raymond C. McKay, Cleveland; Harrry F. Rapp, Portsmouth; William L. Potts, Columbus; John C. Woodland, Mt. Vernon; Oren A. Beatty, Mansfield; Arnold B. Kurlander, Columbus; Herman J. Nimitz, Cincinnati; and John A. Prior.

Approval of the petition was given by the American Trudeau Society on December 9, 1949. In the meantime a Committee on Constitution was appointed to draft a Constitution and By-Laws. The Committee included Drs. Potts, Nimitz and Stocklen.

The full support of the finances and staff of the Ohio Tuberculosis and Health Association was offered the new group. It was decided that the Ohio Trudeau Society should act as the medical section of the Ohio Tuberculosis and Health Association in much the same relation the American Trudeau Society is to the National Tuberculosis Association.

Meetings are to be held at the time and place of the meeting of the Ohio Tuberculosis and Health Association except that additional meetings will be at the discretion of the membership.

The first regular meeting since the application for charter was approved will be held at the Neil House in Columbus on June 1 at the same time as the annual meeting of the Ohio Tuberculosis and Health Association.

Dr. Prior has asked Drs. Klassen, Wetterauer and Kurlander to serve as a Program Committee. Interested physicians are invited to submit short papers on tuberculosis and allied diseases of the chest. The Committee has secured Dr. Robert Bloch, Professor of Medicine and Chief of the Division of Pulmonary Diseases, University of Chicago Clinics, Chicago, as speaker and discussion leader.

All physicians are invited to attend. Communications relative to the meeting may be directed to the Ohio Tuberculosis and Health Association, 1575 Neil Avenue, Columbus 1, Ohio.

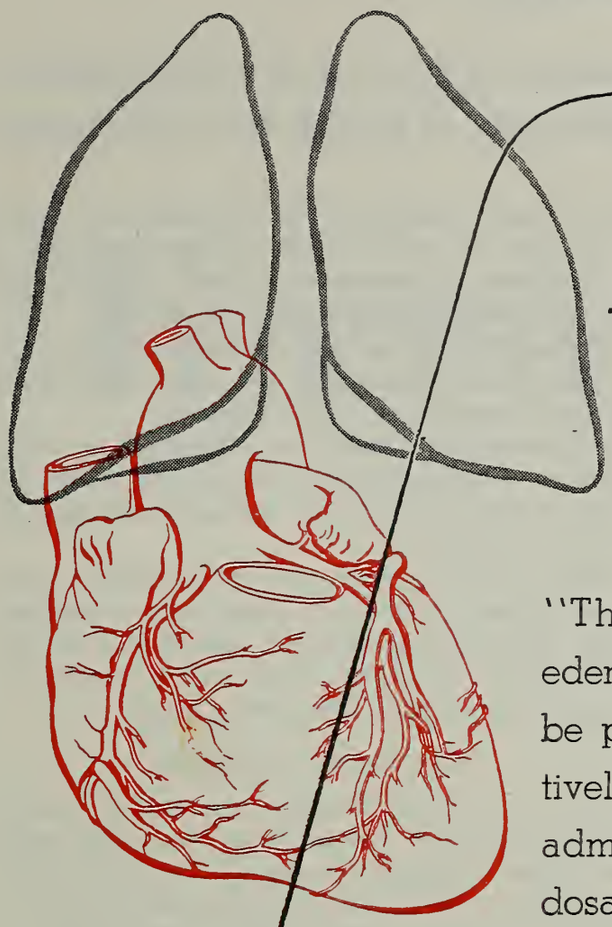
Brookings Workers Visit A. M. A.

Three staff members of the Brookings Institution in Washington spent several days at A. M. A. headquarters recently, discussing the institution's study of "Availability of Medical Service in the United States." This study, the most comprehensive ever conducted in the health service field, will require several years to complete.

The three staff members are: Mr. Benjamin B. Kendrick, research associate, who will devote most of his time to the broader aspects of the study relating to voluntary and compulsory health insurance; Miss Stella Lackey, assistant to Dr. George W. Bachman, senior staff member, who is to devote her time to an over-all study of private practice, hospitals and clinics, and to coordinate information which will be gathered concerning union activities, industry and philanthropy; and Dr. Emma Ward, who is making a specific study of medical services in industry and medical care programs provided by industry.

While the three workers "headquartered" with the A. M. A. Council on Medical Service during their visit, they contacted many of the other staff and bureau heads for the purpose of ascertaining the type and quantity of data available to them in the A. M. A. building.

It is likely that the Brookings people will be contacting state medical associations soon for assistance in securing certain information from the various states.



PULMONARY EDEMA AND PAROXYSMAL CARDIAC DYSPNEA

"The development of pulmonary edema at night may in certain cases be prevented and in addition effectively treated by intramuscular . . . administration of aminophyllin in dosages of 0.5 Gm."[1]

The diuretic action of Searle Aminophyllin frees the tissues of excessive fluid; its myocardial stimulating action improves the efficiency of heart contractions.

G. D. Searle & Co., Chicago 80, Ill.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SEARLE AMINOPHYLLIN*

ORAL...PARENTERAL...RECTAL DOSAGE FORMS

*Contains at least 80% of anhydrous theophylline.

SEARLE *RESEARCH IN THE SERVICE OF MEDICINE*

1. Barach, A. L.: Edema of the Lungs, Am. Pract. 3:27 (Sept.) 1948.

Animal Disease Reporting . . .

More Adequate Control of Diseases Common to Live Stock and Humans Is Object of Program Sponsored by Departments of Health and Agriculture

BECAUSE of the close relationship between many diseases of human beings and animals, physicians will be interested in a new program intended to educate the public toward more adequate control. The report is quoted from a recent issue of *Ohio's Health*, a publication of the Ohio Department of Health.

* * *

The Ohio Departments of Agriculture and Health have recently inaugurated a jointly sponsored program to make an animal disease reporting service available to the veterinary profession.

This new program grew out of a need for reliable data on animal diseases. Its objectives are education of the public to the need for adequate veterinary service to control both animal and human diseases; keeping the veterinary profession informed of disease incidence, distribution, and trends; provision of a basis for intelligent planning of public health and livestock regulatory programs by correlating animal and human disease information; and the evaluation of disease control programs.

BEGAN ON SMALL SCALE

Last year the program was tried on a small scale. The Committee on Public Health of the Ohio State Veterinary Medical Association then recommended that the Association support the establishment on a state-wide basis of a practical system for the collection of such information. This reporting service went into effect late in January.

There are three state agencies interested in the diseases of animals. The Department of Agriculture is responsible for protecting the livestock industry against the ravages of disease. The Department of Natural Resources finds it necessary to consider disease problems as they relate to the preservation of wildlife. The department of Health is concerned with the relationship between the diseases of man and animals.

COMMON INTERESTS

The interests of these three departments, of necessity, overlap considerably. Rabies, in addition to being a public health problem and the cause of considerable livestock loss, also is of interest to the Department of Natural Resources because of the apparent reservoir among foxes and other wildlife in some sections of the state.

Bovine tuberculosis, while primarily a problem of the Department of Agriculture, cannot be ignored by public health people because of its possible transmission to man through the use of meat and milk of affected animals. Conservation officials, too, must consider the problem of tuberculosis because of the close relationship between domestic and wild animals.

The satisfactory handling of the public health problem of brucellosis must depend upon the ultimate elimination of the disease from the livestock of the state.

While swine erysipelas is not a serious public health problem, it must be given serious consideration by the Department of Agriculture as well as by the Department of Natural Resources because of its possible effect on wildlife.

COOPERATION NECESSARY

In view of these common interests in animal diseases, adequate control programs make necessary close cooperation between the various departments. Satisfactory coordination will not be possible, however, until reliable information on the occurrence and distribution of these diseases is available. The veterinarian is the logical source of this data since he must, in his practice, be acquainted with disease problems in his area. For this reason, the Ohio State Veterinary Medical Association is assisting in carrying out the program.

Report cards and franked envelopes are available to private and public health veterinarians through their local health departments. When an outbreak of an infectious disease is diagnosed, the veterinarian need only check or fill in the appropriate blank and mail the card to the Ohio Department of Health. These cards will be processed by the Division of Communicable Diseases and the results made available to the profession at regular intervals, along with other information pertaining to animal diseases.

Veterans Must File for Ohio Bonus by June 30

Eligible Ohio World War II veterans and eligible next of kin of deceased Ohio World War II veterans have until June 30, 1950, to file for the Ohio Bonus, if they have not already done so. The deadline is set by the Constitution. Casualty lists of the Army and Navy reveal that many deceased veterans' next of kin have not filed application for the bonus. Headquarters for the World War II Compensation Fund is at 293 E. Long St., Columbus 15.

Terra firma

In conquering infection, medicine has built a firm and lasting foundation on products derived from the earth.

When it comes to control of infections, be they of bacterial, viral or rickettsial origin—our "terra firma" has provided a widening group of effective antibiotics.

In the screening, isolation, and production of these vital agents, a notable role has been played by the world's largest producer of antibiotics

Pfizer

CHAS. PFIZER & CO., INC., *Brooklyn 6, New York*

Insurance Examination Fees . . .

West Virginia Medical Society Makes Study of Compensation in That State and Comes Up With Some Interesting Facts Regarding Increases

AT a recent meeting of The Council of the West Virginia State Medical Society, the executive secretary submitted the following report regarding fees for examinations made by insurance companies, which will be of interest to Ohio physicians:

* * *

A form letter was prepared and mailed September 1, 1949, to each of the 100 life insurance companies and the 108 casualty, health and indemnity insurance companies licensed to do business in this state. A copy of this form letter has heretofore been furnished to each member of the Council.

INDEMNITY INSURANCE COMPANIES

Casualty, health and indemnity insurance companies do not require medical examinations except in special cases. When the need for such examination arises then the fee is agreed upon by the examining doctor and the insurance company. This policy holds for practically all of the casualty, health and indemnity insurance companies which have replied to our form letter.

LIFE INSURANCE COMPANIES

From the replies received from life insurance companies, it is found that the volume of business of several such companies doing business in West Virginia is not sufficient to require fixed fees for examinations. When examinations are required, then the fee is agreed to in advance by the doctor and the life insurance company.

The overwhelming majority of life insurance companies have heretofore maintained a fixed fee of $5.00 for medical examinations. A few have been paying fees slightly under that amount. No increases in prevailing fees in excess of 50 per cent have been reported by any life insurance company.

FEES INCREASED

As of this date (January 1, 1950), replies have been received from 33 life insurance companies, and from 21 casualty, health and indemnity insurance companies.

The following eight life insurance companies have reported that during the past year fees for medical examinations have been increased from $5.00 to $7.50:

Connecticut General Life Insurance Company
Connecticut Mutual Life Insurance Company
Equitable Life Assurance Society
Fidelity Mutual Life Insurance Company
New York Life Insurance Company
Travelers Insurance Company
Pacific Mutual Life Insurance Company
Bankers Life Insurance Company

This represents a 50 per cent increase in fees over the schedules of these insurance companies previously in effect.

The following four life insurance companies report that during the past year substantial increases have been made in their fee schedules for certain types of medical examinations:

Business Assurance Company
Commonwealth Life Insurance Company
Guardian Life Insurance Company of America
Massachusetts Mutual Life Insurance Company

STUDY BEING MADE

It is interesting to note that six life insurance companies report that the matter of an increase in fees for medical examinations is now being given special study.

Another company, the Acacia Mutual Life Insurance Company, reports that the fee for a medical examination remains at $5.00, but that special fees are allowed where additional information is required.

NO INCREASE CONTEMPLATED

Several life insurance companies report that no increase in fees is contemplated at the present time. Various reasons are assigned for this stand, the principal one being that it is thought inadvisable to increase fees for medical examinations unless premimum rates are increased, and such increase seems improbable at any time in the near future.

Some of the companies feel that a fee of $5.00 is adequate for the services rendered, and others report that there is very little complaint from doctors concerning the amount of the fee paid for this type of service.

No increase in fees for life insurance examinations is being considered at the present time by the following life insurance companies which have replied to our form letter:

American United Life Insurance Company
Equitable Life Insurance Company of Iowa
Farmers and Traders Life Insurance Company

General American Life Insurance Company
Kentucky Central Life and Accident Insurance Company
Liberty Life Insurance Company
Life Insurance Company of Virginia
Metropolitan Life Insurance Company
Minnesota Mutual Life Insurance Company
Mutual Benefit Life Insurance Company
New England Mutual Life Insurance Company
Northwestern Mutual Life Insurance Company
Pan-American Life Insurance Company
Penn Mutual Life Insurance Company
Pilot Life Insurance Company
Provident Mutual Life Insurance Company
Shenadoah Life Insurance Company, Inc.

10,000 Physicians Expected At A. M. A. Meeting

Approximately 10,000 physicians are expected to attend the 99th annual meeting of the American Medical Association in San Francisco, June 26-30. The A. M. A. is the largest medical organization in the world, with a membership of about 144,500.

Attracting the doctors will be the scientific sessions and scientific and technical exhibits. More than 300 papers devoted to medical and surgical progress will be presented by outstanding physicians from all over the world.

"These features provide doctors with information on the latest developments in medicine," said Dr. George F. Lull, Chicago, secretary and general manager of the A. M. A. "It is such meetings as these that enable the nation's medical profession to keep abreast of progress in diagnosis and treatment. The outstanding health record of the United States is the result."

HOUSE OF DELEGATES

The House of Delegates, the policy-making body of the A. M. A. made up of 198 elected representatives of constituent societies and medical departments of the Federal services, will consider matters relating to the health welfare of the country. It also will choose a president-elect, to be installed at the annual meeting in 1951.

Meetings of the House of Delegates will be held in the Palace Hotel. They will be presided over by Dr. F. F. Borzell of Philadelphia, speaker of the House.

The installation of Dr. Elmer L. Henderson of Louisville, Ky., as president will take place on the evening of June 27. Dr. Henderson will succeed Dr. Ernest E. Irons of Chicago. The annual award for distinguished service to the medical profession will be made on that occasion. The winner will be selected by vote of the House of Delegates the day before. The presidential ball will be held June 29. Both events will be in the Palace Hotel.

San Francisco's Civic Center, a group of buildings which has housed some of the largest national conventions, will be used for the scientific portion of the meeting. Scientific sessions, which will cover all phases of medicine and surgery, will be held in several buildings, including the High School of Commerce and Masonic Hall. A technical display by more than 280 exhibitors will be staged in the Civic Auditorium.

SCIENTIFIC MEETINGS

General scientific meetings will be held on the first two days of the convention. Sectional groups will meet on the next three days.

The section programs will deal with anesthesiology, dermatology and syphilology, diseases of the chest, experimental medicine and therapeutics, gastroenterology and proctology, general practice, internal medicine, laryngology, otology, rhinology, physical medicine and rehabilitation, military medicine and surgery, allergy, nervous and mental diseases, obstetrics and gynecology, ophthalmology, orthopedic surgery, pathology and physiology, pediatrics, preventive and industrial medicine, public health, radiology, general and abdominal surgery and urology.

Of educational interest also will be the presentation of surgical procedures over a closed television circuit. The operations will be performed in one of the local hospitals and transmitted in color to 20 receivers in Masonic Hall.

The 27th annual meeting of the Woman's Auxiliary to the American Medical Association will be held in San Francisco, June 27-30, concurrently with the annual session of the A. M. A., with headquarters at the Fairmont Hotel. Preconvention schedule includes Board and committee meetings on Sunday and Monday, June 25 and 26.

Assistant Surgeon General Talks On Nursing in Cincinnati

The Cincinnati Academy of Medicine was one of the sponsoring organizations of a meeting at which Lucile Petry, Assistant Surgeon General of the U. S. Public Health Service, spoke on the subject, "Nursing Research—How It Affects and Improves Patient Care."

Other sponsoring organizations were the Council on Community Nursing of the Public Health Federation and the Woman's Auxiliary of the Academy of Medicine. The meeting was held at the auditorium of the University of Cincinnati College of Medicine on March 14.

The audience consisted of representatives of those interested in community health and the role in it taken by professional nurses.

Resolutions . . .

Some of the Policy Matters Which House of Delegates Will Be Asked To Consider At 1950 Annual Meeting, Cleveland, May 16, 17, 18

IT is the custom of *The Journal* to publish in advance of the Annual Meeting resolutions which are to be presented for action by the House of Delegates, for the purpose of giving delegates and County Medical Societies an opportunity to study the proposals prior to the meeting.

The following resolution will be presented by delegates from the Toledo Academy of Medicine to the House of Delegates at the 1950 Annual Meeting in Cleveland, May 16, 17 and 18:

"American medicine is being charged by certain factions as offering insufficient medical care. The Profession recognizes that there is basis in part for some of these charges, due to a dearth of General Practitioners and a concentration of doctors in the urban centers. This deficiency of General Practitioners is directly associated with overemphasis on specialization in the university centers resulting in a lack of interns in the Non-University Hospitals, the hospitals which are, and should continue to be, the best training centers for the General Practitioners of Medicine.

"**Whereas** there are 807 approved hospitals[1] in the United States offering a total of 9,124 internships, and

"**Whereas** these hospitals reported only 7,068 first and second year interns on active duty, leaving 2,056 vacancies on 1 September 1948, and

"**Whereas** the University Hospitals comprising only 25 per cent of the approved hospitals, with only 29 per cent of the total beds[2] and only 23 per cent of the total patient admissions, have 47.4 per cent of the available internships with only 17 per cent vacancies—or one intern to each 21 1/3 beds—leaving the Non-University Hospitals with 70 per cent of the total vacancies—or one intern to every 60 beds, and

"**Whereas** this critical shortage of interns is working a hardship on the Non-University affiliated hospitals which are taking care of 77 per cent of the patients in our country, making it more difficult for them to render adequate service, resulting in poor public relations for the profession, therefore,

"**Be it resolved** that the approved hospitals of the City of Toledo, through the Academy of Medicine of Toledo and Lucas County, hereby petition the Ohio State Medical Association to urge the American Medical Association to request that the teaching University Hospitals directly connected with their medical schools cease to offer first year rotating internships, thus making available approximately 1500 graduates each year to fill the large number of vacancies in the Non-University affiliated hospitals. The first year men thus released under this plan would receive an intimate association with the general practice of medicine in these Non-University affiliated hospitals and be stimulated to enter this field, thus helping to relieve the critical shortage of General Practitioners which is so acute today."

REFERENCES

1. J. A. M. A., Vol. 140, No. 2, May 14, 1949, pp. 157, 158.
2. J. A. M. A., Vol. 140, No. 2, May 14, 1949, pp. 161 through 170.

* * *

At a recent meeting the Board of Directors of the Cleveland Academy of Medicine adopted the following resolution which will be presented by Cleveland delegates to the House of Delegates of the State Association at the Cleveland meeting:

Whereas:

Chapter III, Article VI, Section 6, of the recently adopted revised Principles of Ethics of the American Medical Association reads:

"PURVEYAL OF MEDICAL SERVICE"

Sectiton 6.—A Physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

Whereas:

The committee known as the "Hess" Committee reported to the American Medical Association House of Delegates in Atlantic City in June 1949, in detail, regarding the Practice of Medicine by Hospitals.

Whereas:

The "Hess" report in one paragraph stated in explanation as follows: "Therefore, hospitals and medical schools cannot charge patients fees for medical services rendered by physicians even though the physicians are full time employees of an individual or institution.

Whereas:

The "Hess" report was adopted by the American Medical Association House of Delegates and the Trustees of the American Medical Association were instructed to enforce the principles and obligations involved.

Whereas:

The House of Delegates of the American Medical Association in Washington in December, 1949, reaffirmed its belief in and confirmed the principles stated in the "Hess" report and directed that action by the Trustees be deferred only until all legal requirements were met in order to insure that all actions taken shall comply with the law.

Whereas:

The Trustees of the American Medical Association are to report to the House of Delegates

point of departure

for special

feeding cases...



Dryco is not only the point of departure for almost every type of infant formula—it is also in itself a valuable food for special cases. Dryco assures ample protein intake while its low fat ratio and moderate carbohydrate content minimize digestive disturbances.

The applicability of the Dryco formula is strikingly seen in an observation by Pitt: "The majority of cases of infant diarrhea, seen in private practice, are of such nature that changing the formula to one of low fat and low carbohydrate is all that is necessary to correct the condition..." Dryco is specifically recommended for use in these cases.*

In addition to formula flexibility, Dryco offers other advantages.

Dryco's special drying process makes it more easily digested by certain infants than the fresh milk from which it is made. It supplies more minerals, particularly more calcium, than a corresponding formula of whole milk, plus 2500 U.S.P. units of vitamin A and 400 U.S.P. units of vitamin D per reconstituted quart. Only vitamin C need be added. Each tablespoonful supplies 31½ calories. Readily reconstituted in cold or warm water.

Available at pharmacies in 1 and 2½ lb. cans.

**Pitt, C.K.: The Art and Science of Artificial Infant Feeding, J.M. Asso. Ala. 19:101 (Oct.) 1949.*

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in June, 1950, regarding this matter and the "Hess" Committee is to report its further study.

Therefore, be it resolved:

The House of Delegates of the Ohio Medical Association confirms the action of the American Medical Association House of Delegates regarding the reaffirmation of the Principles of the so-called "Hess" report.

Be it further resolved:

The House of Delegates of the Ohio State Medical Association requests the American Medical Association House of Delegates to expedite action and Implement methods that WILL enforce the Section 6, Article VI, Chapter III of the Principles of Medical Ethics without delay.

Be it further resolved:

Our delegates to the American Medical Association are hereby instructed regarding these desires and requested to work for their fulfillment.

* * *

A resolution similar to the one above was adopted by the Columbus Academy of Medicine, with instructions to have it introduced at the Cleveland meeting.

Association Assigned Health Aspects Of Institute on Education by Radio

The health education aspects of the program of the annual Institute for Education by Radio, a nation-wide affair sponsored by the Ohio State University, has been taken over this year by the Ohio State Medical Association.

The Association has asked for and received the cooperation of the Illinois State Medical Society in the presentation of the main feature of this year's program, which will be a special session devoted to the televising of the dramatic program, "Guardians of Your Sleep," a simulated surgical operation emphasizing anesthesia.

This program is one of the "Health Talk" series, televised weekly by the Educational Committee of the Illinois State Medical Society in cooperation with WGN-TV, Chicago. At the Institute meeting, the program will be televised as a public service feature over WBNS-TV, Columbus, Saturday evening, May 6, marking the first time that television has been made a formal part of the meeting.

This particular program was selected for presentation in Ohio by the Educational Committee and by the Council of the Illinois State Medical Society. The program and Chicago arrangements are under the direction of Miss Ann Fox, Secretary to the Educational Committee.

Members of the health education study group of the Institute will view the telecast in the studios of WBNS-TV. Others may see the program from television receiving sets which will be set up in the meeting room at the Deshler-Wallick Hotel. The health education group will again meet Sunday morning, May 7, at the Deshler-Wallick Hotel to discuss the special program and other aspects of television and radio.

The Ohio Chemical Company through its dealers, the Columbus Hospital Supply and the Wendt-Bristol Companies, are providing part of the equipment. Other equipment will be furnished by the Ohio State University Hospital. A complete complement of hospital equipment will be available in the studios of WBNS-TV to lend authenticity to the telecast. Abbott Laboratories is making possible the transportation of the cast from Chicago.

Chicago participants, who will make the one day trip by plane for the telecast, are Dr. Max S. Sadove, associate professor and head of the division of anesthesia, University of Illinois College of Medicine; Dr. James H. Cross, clinical assistant in surgery at Illinois; Dr. Allan Talbott, resident in anesthesia, Veterans Administration, Hines, Illinois; Dr. Theodore R. Van Dellen, assistant dean at Northwestern University Medical School; and Mr. Edward Pelikan, senior pharmacology student at Illinois, who portrays the "patient" in the telecast. Miss Sarah Timms, R. N., supervising nurse, Surgical Pavilion, Ohio State University Hospital, also will participate.

Dr. Jonathan Forman, Editor of *The Ohio State Medical Journal*, is chairman of the health education work study group of the Institute and local arrangements for the special program are being handled by the Public Relations staff of the Ohio State Medical Association.

Luncheon, May 17, For Women Physicians Is Planned

A luncheon to which all women physicians are cordially invited will be held on Wednesday, May 17, 12:30 P. M., at Hotel Hollenden, Cleveland, during the 1950 Annual Meeting of the Ohio State Medical Association.

The luncheon is being sponsored by the Cleveland Branch, American Medical Women's Association.

Reservations for the luncheon may be made at the Annual Meeting Registration Headquarters, Cleveland Public Auditorium, by those registering on Tuesday, May 16, and Wednesday morning, May 17.

Dr. Alvarez To Edit *GP*

Dr. Walter Alvarez, senior consultant in the Division of Medicine in the Mayo Clinic, has been appointed medical editor of *GP*, published by the American Academy of General Practice.

Dr. Alvarez succeeds Dr. F. Kenneth Albrecht, who died following an automobile accident. Managing publisher is Mr. Mac F. Cahal, executive secretary of the Academy.

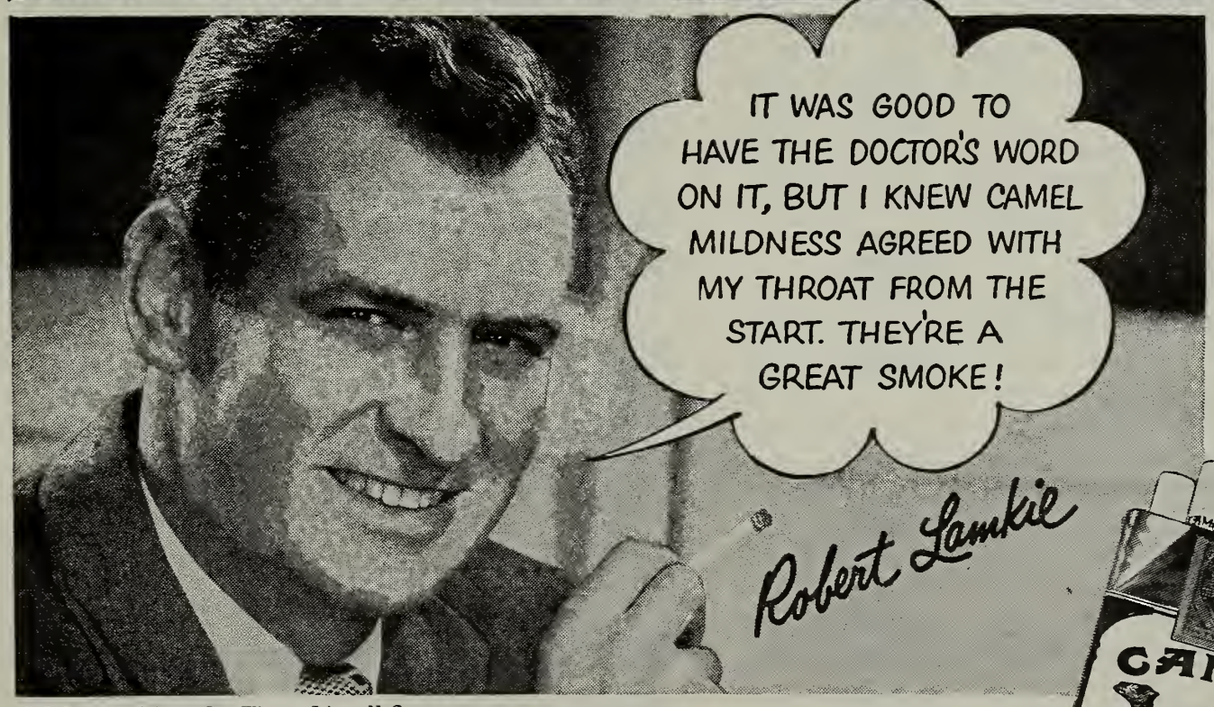
THROAT SPECIALISTS REPORT

ON 30-DAY TEST OF CAMEL SMOKERS:

"Not one single case of throat irritation due to smoking Camels!"

Yes, these were the findings of throat specialists after a total of 2,470 weekly examinations of the throats of hundreds of men and women who smoked Camels—and only Camels—for 30 consecutive days.





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One of hundreds of people from coast to coast who made the 30-Day Camel mildness test under the observation of throat specialists.

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ACCORDING TO A NATIONWIDE SURVEY:

MORE DOCTORS SMOKE CAMELS

THAN ANY OTHER CIGARETTE



Yes, doctors smoke for pleasure, too! In o nationwide survey, three independent reseorch organizations asked 113,597 doctors what cigarette they smoked. The brand named most was Camel.

ANNUAL AUDIT OF BOOKS OF THE OHIO STATE MEDICAL ASSOCIATION AND THE OHIO STATE MEDICAL JOURNAL FOR YEAR ENDING DECEMBER 31, 1949, BY KELLER, KIRSCHNER, MARTIN & CLINGER, CERTIFIED PUBLIC ACCOUNTANTS, COLUMBUS, OHIO

OHIO STATE MEDICAL ASSOCIATION

Cash and Bonds on Hand at January 1, 1949:		
Cash in Huntington National Bank		$ 24,934.76
Cash in Ohio National Bank		60,195.00
U. S. Treasury and Savings Bonds		70,000.00
Total cash and bonds on hand, January 1, 1949		$155,129.76
RECEIPTS		
Interest on U. S. Treasury and Savings Bonds	$ 1,750.00	
1949 Membership dues collected in 1949	51,125.00	
1950 Membership dues collected in 1949	41,175.00	
1949 Exhibit space collected in 1949	6,041.50	
1950 Exhibit space collected in 1949	4,682.00	
Banquet Tickets sold, Annual Meeting	2,557.50	
Membership directories	180.00	
Osmagram cash fund, transferred	26.00	
Ohio State Medical Journal reimbursement for equipment and repairs	1,823.84	
Total receipts		$109,360.84
U. S. Savings Bonds purchased in 1949		10,000.00
Total To Be Accounted For (Includes 1950 Dues and 1950 Exhibit Payments, Collected in Advance)		**$274,490.60**
DISBURSEMENTS		
Ohio State Medical Journal	$ 20,000.00	
Executive Secretary, salary	10,000.00	
Executive Secretary, expense	1,310.41	
Stenographic and Clerical Personnel, salaries	11,692.68	
President, expense	441.62	
Council, expense	1,562.09	
A. M. A. Delegates, expense	2,556.75	
Conference of County Society Presidents and Secretaries	931.28	
Department of Public Relations:		
Director, salary	8,500.00	
Director, expense	1,464.22	
Assistant Director, salary	4,800.00	
Assistant Director, expense	458.91	
Exhibits and newspaper publicity	588.52	
Literature	10,054.51	
Postage and supplies	2,559.09	
Miscellaneous expense:		
Part - time clerical, salaries $2,404.00		
Other 583.95	2,987.95	
Standing Committees:		
Education	142.25	
Public Relations and Economics	308.31	
Scientific Work	677.32	
Special Committees:		
Auditing and Appropriations	180.00	
Cancer	52.31	
Industrial Health	506.27	
Medical Care of Veterans	872.41	
Postgraduate Programs	15.00	
Rural Health	561.32	
School Health	402.69	
Annual Meeting	13,451.84	
Retirement fund	2,366.62	
Postage, telephone, and telegraph	2,333.89	
Professional Relations Activity: (Osmagram and miscellaneous)	5,307.91	
Stationery and supplies	2,285.41	
Rent	6,017.88	
Employees' position bond, insurance, Social Security	625.46	
Collection of A. M. A. assessment (supplies and postage)	1,173.75	
Fifty-Year membership certificates	161.80	
Miscellaneous	376.39	
Office equipment	1,669.34	
Office repairs	243.38	
Rural Medical Scholarship	500.00	
Woman's Auxiliary to Ohio State Medical Association	300.00	
World Medical Association	500.00	
Employees' bonus	3,071.67	
Purchase of U. S. Savings Bond, Series G	10,000.00	
Total disbursements		$134,011.25
Cash on Deposit and Bonds on Hand, December 31, 1949:		
Huntington National Bank	$ 19,304.35	
Ohio National Bank	41,175.00	
U. S. Treasury and Savings Bonds	80,000.00	
Total cash and bonds on hand, December 31, 1949		140,479.35
Total Accounted For (Includes 1950 Dues and 1950 Exhibit Payments, Collected in Advance)		**$274,490.60**

THE OHIO STATE MEDICAL JOURNAL

ASSETS

Current Assets:		
Cash in Ohio National Bank		$ 1,080.82
Petty cash		10.00
Total cash		$ 1,090.82
Accounts receivable: Advertisers		1,698.39
Postage deposit		65.00
Total current assets		$ 2,854.21
Property Assets:		
Furniture and equipment (depreciated value)		9,615.39
Total Assets		**$ 12,469.60**

LIABILITIES

Deferred Credits: Advertising, 1950		$ 9.50
Surplus, December 31, 1948	$ 13,780.13	
Less overexpended income for year ended December 31, 1949	1,320.03	
Surplus, December 31, 1949		$ 12,460.10
Total Liabilities		**$ 12,469.60**

STATEMENT OF PROFIT AND LOSS

Income:		
Advertising, gross		$ 30,728.05
Less:		
Commission on advertising	$ 1,949.32	
Discount on advertising	950.99	2,900.31
Advertising income, net		$ 27,827.74
Ohio State Medical Association appropriation		20,000.00
Subscriptions and sales		677.81
Total income, net		$ 48,505.55
Expenses:		
Journal printing	$ 35,006.31	
Printing, other	12.72	
Salaries	9,420.00	
Traveling expense	47.49	
Postage for Journal	829.49	
Postage, miscellaneous	269.75	
Illustrations and engravings	236.96	
Journal envelopes	1,036.27	
Auditing	50.00	
Clipping service	225.00	
Dues and subscriptions	19.20	
Office supplies and expense	1,006.11	
Employees' bonus	690.00	
Depreciation	956.28	
Bad debts	20.00	
Total expenditures		49,825.58
Deficit for the year		**$ 1,320.03**

Hospital Subject To Taxation . . .

In Recent Majority Decision, Ohio Supreme Court Holds Institution Can Be Taxed When It Profits From Services of Its Staff Physicians

A RECENT majority decision rendered by the Ohio Supreme Court has an important bearing on the tax status of a hospital that profits from the conduct of its affairs, which may include (as in the case decided) a profit from services rendered by members of its medical staff. In the case at issue the court held the hospital subject to taxation.

The case decided by the Supreme Court was that of Cleveland Osteopathic Hospital, Appellant, v. Zangerle, Aud., et al., Appellees. (No. 31960.)

Following is a report of the majority and minority decisions of the court, as reported in the March 20 issue of the Ohio Bar, pages 222-234, inclusive:

STATEMENT OF THE CASE

1. Whether the real property of a privately owned and operated hospital is property belonging to an institution used exclusively for charitable purposes and exempt from taxation as such under the provisions of Section 5353, General Code, is a question of fact in each individual case.

2. Based on the theory that all property should bear its proportionate share of the costs of government and that it should be absolved from such obligation only for good cause, taxation is the rule and exemption the exception.

3. One seeking to have property relieved from taxes has the burden of showing that such property comes squarely within exemption provisions of the organic law or a valid statute.

4. Where on a hearing of an application by a privately owned and operated hospital for the exemption of its real property from taxation under the last part of Section 5353, General Code, referring to "charitable purposes," it appears from the evidence before the Board of Tax Appeals that most of the patients admitted to and cared for in such hospital pay for their accommodations at the established rates, that physicians and surgeons are employed by such hospital on salaries and that the hospital collects and appropriates the charges made for the professional services they render, which amounts greatly exceed the salaries paid, and that from the manner of its over-all operation the hospital designedly makes a substantial annual profit, a decision by the Board of Tax Appeals that the property of such hospital by reason of its use should not be exempted from taxation will not be reversed by the Supreme Court as unreasonable or unlawful on a statutory appeal from the board's decision.

Appeal from the Board of Tax Appeals.

The Cleveland Osteopathic Hospital, an Ohio corporation not for profit, made application to the Board of Tax Appeals to have certain of its real estate situated in the village of Bay taxing district, Cuyahoga county, Ohio, exempted from taxation for the tax year 1949 on the basis that it is property belonging to an institution used exclusively for charitable purposes. The specific property involved is designated as the west side branch, is called Bay View Hospital and has accommodations for about fifty patients.

After a hearing, the board denied exemption and an appeal was then taken to this court under favor of Section 5611-2, General Code.

The evidence offered and received on the hearing of the application for exemption shows an unusual situation. It discloses that several—six or seven—osteopathic physicians and surgeons voluntarily withdrew from private practice and became employees of the hospital at salaries of about $1,000 per month each. They continued to see and treat patients at the hospital and elsewhere much in the same manner as they had formerly done as private practitioners, making the usual charges for services rendered. However, the hospital became the recipient and beneficiary of the amounts so charged and collected. It also sent out statements covering the services performed and received and appropriated the sums paid thereon. Apparently, this plan is to be a continuing one.

STATEMENT AS EVIDENCE

Introduced in evidence as an exhibit is a statement of the receipts and expenditures of the Cleveland Osteopathic Hospital for the Calendar year 1948. It shows total receipts of $485,532.15 and total expenditures of $374,525.09, leaving a net operating profit of $111,007.06.

For the professional services rendered by the several physicians and surgeons referred to above, the hospital collected $182,242.07, while paying them as compensation or salaries the sum of $81,433.49.

The sum of $134,355.51 was received from "regular patients" and the sum of $102,003.64 from the "Cleveland Hospital Service Association."

Under "Expenditures," the sum of $8,172.78 is listed for "free service" and the sum of $1,405.71 for "courtesy service."

The witness for the applicant hospital testified that profits made from the operation of the hospital had been and would be applied in paying

off indebtedness and in improving and enlarging hospital facilities.

OPINION, PER ZIMMERMAN, J.

Zimmerman, J. On the present appeal, it becomes the duty of this court to decide the ultimate question whether *under the evidence adduced in this particular case*, the decision of the board is unreasonable or unlawful.

In the hearing before the board and on the presentation of this appeal, the hospital relies wholly on that part of Section 5353, General Code, which reads:

"Real and tangible personal property belonging to institutions used exclusively for charitable purposes, shall be exempt from taxation."

Based on the theory that all property should bear its proportionate share of the costs of government and property should be absolved from such obligation only for good cause, taxation is the rule and exemption the exception. Hence, one seeking to have property relieved from taxes has the burden of showing that such property comes squarely within the intent and meaning of exemption provisions. See *Crown Hill Cemetery Assn.* v. *Evatt, Tax Commr.*, 143 Ohio St., 399, 55 N. E. (2d), 660; *Welfare Federation of Cleveland* v. *Glander, Tax Commr.*, 146 Ohio St., 146, 174, 64 N. E. (2nd), 813, 825; *Battelle Memorial Institute* v. *Dunn, Aud.*, 148 Ohio St., 53, 59, 60, 73 N. E. (2d), 88, 91.

It seems obvious that no single test is dispositive of whether a hospital, for example, is being conducted *exclusively* as a charitable project. All the facts in each individual case must be assembled and examined in their entirety and the substance of the scheme or plan of operation exhibited thereby will determine whether the institution involved is entitled to have its property freed from taxes.

ILLUSTRATION

An illustration of the above statement is to be found in the cases of *American Issue Publishing Co.* v. *Evatt, Tax Commr.*, 137 Ohio St., 264, 28 N. E. (2d), 613, where under the peculiar facts of that case the property of a printing plant was held entitled to tax exemption and *Zindorf* v. *Otterbein Press*, 138 Ohio St., 287 34 N. E. (2d), 748, where under the peculiar facts of that case the property of another printing establishment was held subject to taxation, principally because it was in competition with other concerns engaged in commercial printing and because a profit motive was plainly discernible from the manner in which it ran its business. Compare, *Incorporated Trustees of the Gospel Workers Society* v. *Evatt, Tax Commr.*, 140 Ohio St., 185, 42 N. E. (2d), 900.

To the writer, at least, the adjective "charitable" attached to "hospital" conveys the idea of a place where service and assistance are given the sick, injured and ailing, with open doors and benevolent concern for afflicted souls who lack the ability to pay for the attentions they receive.

Predicated upon language used in the opinion in the case of *O'Brien, Treas.*, v. *Physicians Hospital Assn.*, 96 Ohio St., 1, 116 N. E., 975, L. R. A. 1917F, 741, and in accordance with the concept of an organization devoted *exclusively* to charitable purposes, a hospital to qualify as a charitable institution, the property of which is exempt from taxation, should have as an important objective the care of the poor, needy and distressed who are unable to pay, although the fact that it admits and ministers to a number of pay patients will not necessarily destroy its charitable character. See *Trust Company of Georgia* v. *Williams*, 184 Ga., 706, 192 S. E., 913.

But where a hospital extends its facilities and services very largely to those who are able to and do pay the established rates for their accommodation and *designedly makes a very substantial profit* in so doing, it places itself in the classification of a business enterprise amenable to taxation, nothwithstanding that some unfortunate persons without means are cared for free of charge. See 51 American Jurisprudence, 607, Section 635.

PECUNIARY GAIN

In the instant case it is plain from the figures presented that services and accommodations of all kinds for which charges were made and collected greatly exceeded the services performed and the accommodations furnished without charge and that by the procedure adopted and followed the pecuniary gain to the hospital was considerable.

The bare fact that a hospital devotes the profits it makes from the conduct of its affairs to paying off indebtedness and to improving and enlarging its plant does not of itself place it in the category of a tax exempt charitable institution. It is the use of the property and not the use of the proceeds derived therefrom which is determinative of the question of tax exemption. See *Benjamin Rose Institute* v. *Myers, Treas.*, 92 Ohio St., 252, 110 N. E., 924, L. R. A. 1916D, 1170, *Incorporated Trustees of Gospel Workers Society* v. *Evatt, Tax Commr., supra; Burns* v. *Glander, Tax Commr.*, 146 Ohio St., 198, 64 N. E. (2d), 678; *Battelle Memorial Institute* v. *Dunn, Aud., supra* (148 Ohio St., 53, 61, 73 N. E. [2d], 88, 92); *New Orphans' Asylum of Colored Children of Cincinnati* v. *Board of Tax Appeals*, 150 Ohio St., 219, 223, 80 N. E. (2d), 761, 763.

One recognized test for ascertaining whether a hospital is charitable or otherwise is whether it is maintained and conducted for gain, profit or advantage. 14 Corpus Juris Secundum, "Charities," 422, Section 2. And this is a question of fact in each individual case. *Hamilton* v.

Corvallis General Hospital Assn., 146 Ore., 168, 30 P. (2d), 9.

It has been held that if the books of a hospital show a substantial profit, that is a circumstance tending to negative the idea that it is a benevolent institution. *Prairie du Chien Sanitorium Co.* v. *City of Prairie du Chien*, 242 Wis., 262, 7 N. W. (2d), 832, 144 A. L. R., 1480.

SALARY FIXING

In 2 Restatement of Trusts, 1167, Section 376, under Comment *b.*, is the following language:

"The mere fact that persons who are not objects of charity incidentally benefit from the maintenance of a charitable institution does not prevent the institution from being charitable. Thus, an institution for the promotion of charitable purposes is charitable although salaries are paid to its managers, officers and employees. *If, however, the fixing of a salary is merely a device for securing the profits of the institution and not merely compensation for services rendered, the institution is not a charitable institution.*" (Emphasis ours.)

Here, the compensation paid the physicians and surgeons working as employees of the hospital was a good deal less than the returns which the hospital enjoyed by reason of the services performed for its benefit by such physicians and surgeons. As a matter of fact, the amounts collected by the hospital for these services contributed in an appreciable degree to the tidy profit it garnered in 1948.

As concerns the problem of tax exemption in Ohio, cases from other jurisdictions are ordinarily not very helpful, because, more often than not, the tax-exemption provisions under which they were decided differ materially from the provisions on the same general subject obtaining in this state.

In the pending controversy, the Board of Tax Appeals found as a fact that the use made of the property for which tax exemption is sought did not bring it within the applicable exemption provisions of Section 5353, General Code, and rendered its decision accordingly. A majority of this court is of the opinion that such decision is not unreasonable or unlawful, under all the facts and circumstances developed, and it is therefore affirmed.

Decision affirmed.

Weygandt, C. J., Mathias and *Turner, JJ.*, concur.

Hart, Stewart and *Taft, JJ.*, dissent.

DISSENTING OPINION, PER TAFT, J.

Taft, J., dissenting. The facts in this case as supported by the record and the findings of the Board of Tax Appeals thereon, were stated by the board as follows:

"The institution is incorporated not for profit.

"In all matters and things save in two respects the property of this institution and its manner of use and operation is comparable to other exempted hospital property and would be entitled to the same privilege of exemption.

"Instead of reciting all of the facts we deem it wise to fully set forth wherein the properties' use differs from other hospitals. This institution encountered financial obstacles in attempting to secure funds to purchase its present site, remodel the building thereon and for its equipment. The osteopathic fraternity of Cleveland and vicinity sponsoring its aims, when banks and other financial institutions refused to advance funds, by donations and personal loans to it, provided the funds to make the institution possible. In order that these loans might be repaid and supply house credits extended be liquidated, this fraternity devised the plan of employing some of its doctor members upon a monthly salary averaging $1,000 a month. All services rendered by them within and without the hospital were and are paid for directly to the hospital. These doctors make no independent charge therefor. The hospital receives all the earnings they produce. They have, in fact, retired from private practice. This plan has worked to the extent that the hospital's operation for the year 1948 shows a net profit of $111,007.06. It is evidenced that the first six months of 1949 show comparable earnings. These earnings are being used to liquidate the institution's construction and equipment indebtedness.

FUNDS FOR ENLARGEMENT

"The evidence produces another fact that the applicant intends to pursue this policy after these debts are paid for the purpose of providing funds for further enlargement and betterment of its hospital facilities.

"It is clear, from the statement made of the facts unhesitatingly disclosed, that although this property is in part used for the dispensing of charity, it is being so used as to produce a profit from its operation and that the income or earnings are being used in freeing the institution of debt."

The record further shows without dispute, that the arrangement made with these doctors (herein referred to as the doctors) clearly represented a great financial sacrifice by them.

As the Board of Tax Appeals stated, if this arrangement had not been made so that appellant's receipts exceeded its expenditures in 1948, the board would have found appellant entitled to tax exemption.

As shown by the figures in the statement of facts prepared by the majority and recognized by the statements in the majority opinion, the doctors, instead of receiving $182,000 during the year for their services, received only $81,000. This difference of $101,000 obviously represents

the contribution to the hospital of their services to the extent of that dollar amount.

Heretofore, this court has always recognized that the mere fact, that a profit is realized from the operations of an enterprise, does not mean that such enterprise is not operating exclusively for charitable purposes if such profit is devoted to the charitable purposes of the enterprises. *American Issue Publishing Co.* v. *Evatt, Tax Commr.*, 137 Ohio St., 264, 28 N. E. (2d), 613; *Cullen* v. *Schmit*, 139 Ohio St., 194, 39 N. E. (2d), 146; *Am. Jersey Cattle Club* v. *Glander, Tax Commr.*, 152 Ohio St., 506, 513. See *O'Brien, Treas.*, v. *Physician's Hospital*, 96 Ohio St., 1, 116 N. E., 975, L. R. A. 1917F, 741 (syllabus five); *Taylor, Admr.*, v. *Protestant Hospital Assn.*, 85 Ohio St., 90, 99, 96 N. E., 1089, 39 L. R. A. (N. S.), 427.

AUTHORITY FOR CONCLUSION

This conclusion was clearly recognized by the General Assembly in its enactment of Section 5328-1*a*, General Code, in 1945, at the time when it amended Section 5353, General Code.

Authorities outside Ohio uniformly sustain this conclusion. *Nuns of Third Order of St. Dominic* v. *Younkin, Clerk*, 118 Kan., 554, 235 P., 869; *Baylor University* v. *Boyd* (Texas Civil Appeals), 18 S. W. (2d), 700; *Butterworth et al., Exrs.*, v. *Keeler*, 219 N. Y., 446, 114 N. E., 803; *In re Estate of Rust*, 168 Wash., 344, 12 P. (2d), 396; *Virginia Masonic Hospital Assn.* v. *Larson*, 9 Wash. (2d), 284, 114 P. (2d), 976; *Weiss* v. *Swedish Hospital*, 16 Wash. (2d), 446, 133 P. (2d), 978; *In re Estate of Bailey*, 19 Calif. Appeals (2d), 135, 65 P. (2d) 102; *New England Sanitarium* v. *Stoneham*, 205 Mass., 335, 91 N. E., 385; *Bd. of Commrs. of Tulsa County* v. *Sisters of the Sorrowful Mother*, 141 Okla., 32, 283 P., 984. See, also, 51 American Jurisprudence, 608, 3 Scott on Trusts, 2033, Section 376, 14 Corpus Juris Secundum, 423, 424, Section 2.

None of the cases cited in the majority opinion tends to support a contrary conclusion. In *Incorporated Trustees of the Gospel Workers Society* v. *Evatt, Tax Commr.*, 140 Ohio St., 185, 42 N. E. (2d), 900, it was held that the use of the premises for living quarters was the factor which prevented tax exemption. In *Zindorf* v. *Otterbein Press*, 138 Ohio St., 287, 34 N. E. (2d), 748; *Benj. Rose Inst.* v. *Myers, Treas.*, 92 Ohio St., 252, 110 N. E., 924, L. R. A. 1916D, 1170; and *Battelle Memorial Institute* v. *Dunn*, 148 Ohio St., 53, 73 N. E. (2d), 88, tax exemptions were denied because of uses of the property involved for commercial purposes. The tax exemption sought in *New Orphans' Asylum of Colored Children of Cincinnati* v. *Bd. of Tax Appeals*, 150 Ohio St., 219, 80 N. E. (2d), 761, was allowed. In *Trust Co. of Georgia* v. *Williams*, 184 Ga., 706, 192 S. E., 913, unlike the instant case, the hospital was to be open only to those who paid for its services. *Hamilton* v. *Corvallis Genl. Hospital Assn.*, 146 Ore., 168, 30 P. (2d), 9; *Prairie du Chien Sanitarium Co.* v. *City of Prairie du Chien*, 242 Wis., 262, 7 N. W. (2d), 832, 144 A. L. R., 1480, and the underlined portions, quoted in the majority opinion from Comment b, under 2 Restatement of Trusts, 1167, Section 376, involved situations where the hospital or other institution was used as a device to provide profit for its members or promoters. This is the reverse of the instant case where the promoters (the doctors) are used by the hospital to provide funds for its charitable operations.

It is submitted that the more nearly applicable portion of the Restatement is the subsequent Comment d following the Comment b quoted in the majority opinion. Such Comment d reads in part:

"A charitable trust does not cease to be such merely because its operation results in a profit, provided that the profits are to be applied only to charitable purposes. It is only when the profits may be applied to private purposes that the trust ceases to be charitable. The trust is charitable whether the profits are to be used for the purposes of the undertaking producing the profits or for other charitable purposes."

The majority opinion seems to have overlooked that there is a sound legislative reason for granting tax exemption to "property belonging to institutions used exclusively for charitable purposes." The words "charitable purposes" are usually understood to include those purposes, the accomplishment of which is beneficial to the community. *Cleveland Bible College* v. *Board of Tax Appeals*, 151 Ohio St., 258, 264, 85 N. E. (2d), 284; *Waddell, a Minor*, v. *Y. W. C. A.*, 133 Ohio St., 601, 604, 15 N. E. (2d), 140; 2 Restatement of Trusts, Section 368 and Comment b thereon. When it provides for their tax exemption, the General Assembly merely recognizes in a small way the obligation which the state owes to institutions devoted to charitable purposes. 51 American Jurisprudence, 510, Section 504; *Cedars of Lebanon Hospital* v. *Los Angeles County* (Cal. Dist. Ct. of App.), 206 P. (2d), 915; *Myers, Treas.*, v. *Benjamin Rose Institute*, 92 Ohio St., 238, 251, 110 N. E., 929.

JUSTIFIABLE BENEFIT

It might well be argued that, as to hospitals in this state not used as devices to provide profits for stockholders or other individuals, they are of sufficient benefit to the community to justify their treatment as charitable institutions, even if (as they are not in the instant case, all patients are required to pay for the services received from such hospitals. *Weiss* v. *Swedish Hospital, supra*, at 451. This is especially true in Ohio where most communities are

sorely in need of adequate or even some hospital accommodations.

In the instant case, if, instead of devoting over $100,000 of their services to the hospital in 1948 and thereby enabling the hospital to have such an excess of receipts from operations over disbursements, these doctors had contributed that sum in money as a gift to the hospital, no question of its tax exemption could have been raised without specifically overruling previous decisions of this court. *O'Brien, Treas.*, v. *Physician's Hospital, supra; College Preparatory School for Girls* v. *Evatt, Tax Commr.*, 144 Ohio St., 408, 59, N. E. (2d), 142; *Taylor, Admr.*, v. *Protestant Hospital Assn., Supra.*. The interest of the community in having such a hospital is just as great where donations in cash are not available as where they are. That interest is the interest which justifies classification of the hospital as a charity and enables it to secure the tax exemption provided by the General Assembly.

No institution, even a charitable one, can operate at a loss indefinitely. Where cash donations are not available to make up for operating losses, the need of tax exemption is greater than where such donations are available. The mere facts, that a hospital is operated efficiently within its income and supported in part by donations of services instead of cash, should not prevent it from receiving tax exemption. Any distinction between donations of money and donations of services would appear to be a distinction without a difference.

Hart and Stewart, JJ., concur in the foregoing dissenting opinion.

Journal of Proctology

Recently the first issue of a new publication, *The American Journal of Proctology*, was issued. The journal is the official publication of the International Academy of Proctology and is under editorship of Dr. Alfred J. Cantor. The journal will publish original articles on proctology and allied subjects as well as the official proceedings of the scientific sessions of the Academy. Dr. Cantor's address is 43-55 Kissena Blvd., Flushing, N. Y. The publication office of the journal is 1819 Broadway, New York 23.

Dr. Daniel Blain, medical director of the American Psychiatric Association, was guest speaker at the March 13 annual meeting of the Montgomery County Mental Hygiene Association in Dayton.

The Cleveland Health Museum recently gave a preview of a new film, "Challenge: Science Against Cancer." The film has been produced by the National Film Board of Canada and the Association of American Medical Colleges.

Patient Waits and Waits Under Medical Program in England

An Ohio physician has forwarded to the State Headquarters Office excerpts from two letters which have been received by an Ohio business woman. The letters are from a woman in England who holds a responsible position with a business firm in a well-known English city. The excerpts are published here for information of the reader with regard to current conditions in England, concerning which he may wish to advise his patients.

"February 14, 1950

"This reminds me, that I am still without my glasses. Was speaking to a friend the other day, and am told that if an appendicitis operation is necessary, it is a two-year wait to get a hospital bed. Marvellous, we are paying very heavily for our medical benefits, and are getting less and less than before. To have a tooth extraction, you cannot get an appointment under 3 months, that wouldn't be as bad, if you could induce the tooth to cease aching for a similar period.

"No, prevent nationalization where health is concerned if you can help it. It is an expensive luxury. The thing that irritates very much, is the fact that people entering our country are issued with the return of their passports, a document assuring them that they are entitled to free medical benefits, including wigs and artificial limbs whilst over here, and of course a certain type make a point of getting it, and have priority owing to the briefness of their visit. And, of course, they have never contributed a ld (1/12 of a shilling) towards it. Our Health Minister to our protests replies that we are building up a good name for ourselves as a consequence overseas.

"The majority of us are most annoyed that it should ever have been necessary to accept aid from your country, or that it should have been mismanaged and spent in crazy ways after receipt, but there is always a section of the community who believe every fantastic promise made to them, and they cannot, or will not look ahead to the future. So we others are just waiting and praying for Divine help to bring us to sanity, and to teach all that existence is only by personal hard work, and not in existing on the charity of other nations.

"I suppose we are going through a period of evolution but I do hope that we can plan ahead a little more as individuals and not just become automatons under State control. Freedom has always meant such a lot to the English speaking peoples."

* * *

"March 14, 1950

"By the way, I have not yet got my spectacles, and the medical profession is so over-worked filling up Government forms for this and that, they are left with little time for the attention of the sick. Unless you have reached the stage where it is a case of 'either' or 'or' you might as well cure yourself. In addition the extra form filling placed on the doctors has increased the hours worked to anything up to 80 hours per week, by which time they are feeling so ill themselves, that concentration on other peoples illness is almost a sheer impossibility."

United Medical Bill Opposed . . .

Executive Committee of A. M. A. Board of Trustees Issues Statement Against H. R. 5182 Proposing Federal United Medical Administration

A STATEMENT of policy opposing H. R. 5182 which proposes consolidation of certain hospital, medical and public health functions of the Federal Government in a United Medical Administration—one of the recommendations of the Hoover Commission On Organization of the Executive Branch of the Government—has been adopted by the Executive Committee of the Board of Trustees of the American Medical Association after consultation with the Coordinating Committee on Legislation of the A. M. A.

The statement points out that the A. M. A. favors the purpose of the Hoover Commission's recommendation to effect economy in governmental operations but believes that H. R. 5182 falls short of that goal and contains several objectional provisions.

TEXT OF STATEMENT

Following is the text of the official statement issued by the Executive Committee of the A. M. A. Board:

"We are of course in favor of the purpose of the Hoover Commission's recommendation in attempting to effect economy in the operation of the several medical services under the Federal Government, provided that economies can be in reality accomplished without sacrifice of the quality of service rendered and without interfering with the special missions of certain of these services.

"A careful perusal of H. R. 5182 reveals no evidence of how economies are to be accomplished, how the special functions of the several services are to be preserved or how the quality of medical care is to be safeguarded.

AUTHORITY WITHOUT RESTRAINT

"We object also to the administrative provisions of the bill. The administrator, who is to be directly responsible to the President, is given blanket authority to issue regulations having the force of law without any restraint but that of the President and of a Board made up of the Surgeons General of the Army, Navy and Air Force and the Administrator of the Veterans Administration. The United States Public Health Service, with its multiple activities and responsibilities, has no representation on this Board. The Board can act only in an advisory capacity and can in no way control the decisions of the Administrator.

"The American Medical Association has repeatedly advocated the consolidation of the medical activities of the Government other than those of the Veterans Administration and the Armed Forces under a single Department of Health.

"It also believes that an integrated system of hospitals should be developed for the country as a whole, such as is now developing under the Hill-Burton Act. It believes, however, that the consolidation of the medical services as proposed in H. R. 5182 at this time, or until such time as careful study has developed convincing evidence of the wisdom of such a consolidation, would be a risky procedure and fraught with great possibility of harm.

CAREFUL STUDY NEEDED

"The Association is of the opinion that the Congress should proceed slowly in this matter and that any action by the Congress should be preceded by a careful study of the entire problem with particular reference to possible economy, the effect on the quality of medical care and on the execution of the primary missions of the Armed Forces, the Public Health Service and the Veterans Administration.

"It believes that the principal economy to be accomplished is in the coordination of the several Federal hospital systems that would provide for joint use of available beds and joint planning in the field of hospital construction. It believes a central hospital board, clothed with authority to adjust the hospital program to the needs of the services, could gain the ends desired without consolidation of professional personnel."

Planned Parenthood League Medical Board Schedules Luncheon

A luncheon meeting of the Medical Advisory Board, Planned Parenthood League of Ohio, will be held on Wednesday, May 17, at 12:15 p. m., in the Hotel Hollenden, Cleveland, during the Annual Meeting of the Ohio State Medical Association.

Dr. William C. Weir, Cleveland, will preside as chairman of the Medical Advisory Board. He recently succeeded Dr. Allan C. Barnes, Columbus, who is continuing to serve on the Executive Committee. Other members of the committee are Dr. J. H. J. Upham, Columbus, honorary chairman; Dr. M. A. Blankenhorn, Cincinnati; Dr. Harrison Evans, Worthington, and Dr. J. C. Placak, Sr., Cleveland.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

INFLATED COSTS WILL WRECK PROGRAMS

Voluntary health insurance which is the strongest, if not the only, alternative to government-controlled compulsory health insurance, can easily become too expensive for people in the low-income group, Dr. Paul R. Hawley, executive director of the American College of Surgeons and former executive director of the Blue Cross-Blue Shield plans, stated in an address at the 10th anniversary dinner of Hospital Care Corporation (Blue Cross) of Southwestern Ohio, held recently in Cincinnati.

Amplifying this statement, Dr. Hawley said: "Too many people, doctors included, labor under the erroneous impression that health insurance lowers the cost of medical care. It doesn't, and cannot lower it one penny. It only spreads it." He then emphasized that the voluntary hospital and medical plans are at the mercy of hospitals and doctors. Hawley pointed out that hospitals must keep hospital costs reasonable through efficient administration and that physicians must help to prevent abuses by keeping patient admissions on a "necessity" basis and hospital stays at a minimum. Voluntary medical insurance can be "priced" out of business by excessive charging and other abuses, Hawley added.

Dr. Hawley touched once more on the old, old story that it takes only a few bad practices on the part of a few bad actors to kill off something of benefit to everyone concerned.

SHOW AND TELL THEM WHAT WE'RE FOR

"Show Them What We're For" is the headline appearing over an editorial in a recent issue of a medical magazine of national circulation. The point is made in the article that more constructive action by the medical profession is needed; that a better job of letting the people know what the medical profession is doing and stands for, is required.

In our opinion, the recommendation is sound and should be heeded.

The day is past when the physician can go before the public, armed only with arguments against this bill or that program. He must be prepared to tell his listeners about the many things which the medical profession is doing to improve the health of the people; how it is working with many other groups and organizations to make programs in the public's interest effective; what pieces of legislation the medical profession endorses and is actively supporting; why the measures which are fundamentally wrong in principle would be harmful to the people generally—not just why they would adversely affect physicians.

There is a wealth of material on the constructive side which is available to the physician-speaker. "The 25-Point Health Program" of the Ohio State Medical Association and what is being done by medical societies all over the state to promote those points offer the basis for a corking good positive and constructive talk. The history and progress of Ohio Medical Indemnity, the Ohio profession's prepaid medical care plan, make a fascinating story to tell an audience. Most of the County Medical Societies are engaged in important community activities. The public should be told about these. (Unfortunately, the medical profession is still too reticent about tooting its own horn.)

These are merely a few examples among many things which the physician can talk about. If he does just that, he can easily show his audiences by inference that they don't need a lot of the fancy stuff being suggested by the boys along the Potomac.

Of course, if the local medical society is dead on its feet and the majority of the doctors in the county "are too busy" to meet their civic duties—well, there's nothing much to talk about to the folks in that county. That's just too bad, isn't it?

MEDICAL BOARD ON JOB, REPORT REVEALS

Report for the calendar year 1949 of the State Medical Board reveals that the Board's two inspectors investigated 169 complaints of illegal practice and made 1,530 calls in making these investigations. It shows that 65 cases against illegal practitioners were filed in court; convictions secured in 42 cases; two cases dismissed; 21 cases awaiting trial; and five cases from former years concluded.

The Board held 12 regular and special meetings during the year, including hearings concerning suspension or revocation of licenses and the examination of applications for a license in Ohio.

These statistics alone show that the Board is on its toes and doing a real job despite the handicap of inadequate finances, especially for inspection personnel.

One thing is vital when the Board makes a check-up of illegal practitioners in any county: It needs the help and cooperation of the medical profession, especially on the matter of securing competent evidence and proper witnesses. Be-

fore a case is taken to court, sound evidence and reliable witnesses must be obtained. Physicians can be a big help to the Board's inspectors on such matters. Lack of substantial evidence is responsible for the failure in most of the cases which fail to get to court or are dismissed. Also, two inspectors for 88 counties is spreading it pretty thin, but that's all the budget will allow.

"GP" WELCOMED TO THE FOLD

Latest newcomer to the ranks of medical publications is *GP* official magazine of the American Academy of General Practice. The first issue is a beauty. The scientific and clinical material was written by a battery of high-class essayists. The news sections are meaty and well done. *GP* is a healthy looking baby —not so small at that with its 128 pages—and gives promise of quickly becoming an important member of the medical press. Here's wishing it the best of success

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THE TEMPTATION WAS JUST TOO GREAT

An editorial writer in a Northern Ohio newspaper has chastised a physician who, while addressing a gathering of citizens on the Truman health program, put in some plugs for reëlection of Senator Robert A. Taft.

According to the writer of the editorial, the physician should have stuck to his subject and should not have brought the political issue into the talk. He admits that physicians as individuals have a right to be for Taft if they want to, but he makes the point that some of the listeners experienced a feeling of having been tricked because "the meeting had been billed for a discussion of socialized medicine—not as a vehicle for a political rally," and that it was implied that those who do not vote for Taft are "not good Americans."

Although it may be difficult for anyone who is opposed to socialized medicine to be anything but in favor of the reëlection of Taft, the gentleman of the Fourth Estate may have a point worthy of consideration. We don't feel the question which has been raised is nearly as serious as the editorial implies. However, it does present a warning to the physician who takes the public platform. He should stick to his subject; confine himself to the purposes of the meeting; and be diplomatic if he decides to touch on politics.

Doubtless Mr. Taft would agree that he doesn't need platform speakers in his behalf nearly as badly as he needs folks who are willing to go out, rub elbows with folks hither and yon, and tell them in a personal way why they ought to be for the senior Ohio Senator.

WILL OHIO RANK LOW AGAIN IN BIRTH-DEATH REGISTRATIONS?

With the 1940 decennial census, a test was made to determine the thoroughness with which births had been registered in the various states. Ohio, with only 95.6 per cent of births registered during the test period, ranked lowest of the Midwestern States.

A similar test is being made with the 1950 census. This time both birth and death registrations are being counted. The test includes only those births and deaths which occurred during the three-months period January 1 through March 31, 1950. Although the period is now past, leeway will be allowed for certificates which come in late but which register births or deaths for the period.

In addition to their value as vital statistics records, birth and death certificates are bcoming increasingly valuable to individuals, families and heirs.

Ohio is one of the most progressive states and should be at the top of the list as far as registrations are concerned. There is still time if you have a registration for the period not completed, or if you have a colleague who has not completed a registration. And why can't we make it 100 per cent the year 'round?

GOOD WORK BEING DONE IN LORAIN COUNTY

Hats off to the doctors in Lorain County! All but six of the 119 members of Lorain County Medical Society are registered and eligible to vote, according to the Public Relations News Letter of Dr. Theodore Berg, chairman of the Society's P. R. committee. Indications are that the delinquent six will be brought into the fold before too long. Appears as if some good work has been done in Lorain County. Other counties please copy. **Getting every doctor in Ohio registered and then to the polls in November should be the goal of all county medical societies during the ensuing months.** It's a job for the Legislative Committee or a select committee or the Woman's Auxiliary—and a big one.

TOUR OF EXHIBITS SHOULD BE A "MUST" ON YOUR SCHEDULE

Those planning to attend the Annual Meeting, May 16-18, Cleveland, should make repeated tours of the Technical and the Scientific and Educational Exhibits a must. When visiting the booths, each member should register and spend time getting acquainted with the exhibit representatives.

As another state medical society magazine pointed out recently, "our annual meeting would be but a poor shadow of its usual self were it not for the technical or commercial exhibits." It then emphasized that the technical exhibits

bring the doctor up to date on the practical applications of advances in medicine and medical technology and provide a means for getting first hand information on the value and uses of the finest pharmaceutical, biological and surgical tools in existence.

The Scientific Exhibits need no press agent. As in the past they will be of high standard and value. They will present a beneficial course in visual education. Those who have gone to the time and effort to present these displays deserve the support of all in attendance. Visit each one and discuss the subject with the person in charge.

Unless you make a thorough tour of these exhibits—technical and scientific—a "must" part of your schedule you will be overlooking a real bet; you will be letting down the firms, organizations and individuals who are sponsoring the displays.

TOO LITTLE TAUGHT ABOUT WHAT IS RIGHT IN U. S. A.

Commenting on the Hiss case, Raymond Moley in *Newsweek* points out that Hiss was educated in an institution provided by the profits of the very economic system that Communism is determined to destroy. Then Moley adds this admonition which applies to many schools and colleges all over the nation:

"It may well be considered by those who direct higher education in America whether there is not a need to reexamine their responsibilities and the way they are carried out. **The danger is not that there is too much taught about what is right in Communism, but that there is too little taught about what is right in America.**"

MEDICINE LOSES A REAL FRIEND

Through the recent untimely death of Victor L. Keys, Columbus, the Ohio State Pharmaceutical Association lost the services of an efficient, loyal executive secretary and the medical profession of Ohio, a staunch ally.

One of Mr. Keys' last acts was to assist on arrangements for a joint meeting of officials of the Ohio State Pharmaceutical Association and the Ohio State Medical Association. This was held on April 1 for the purpose of discussing in an informal way some of the mutual problems of the two professions. As a result of that meeting, a joint committee has been set up to continue conferences and to draft a proposed joint statement of policy on various matters, to be submitted to each organization for ratification at a later date.

It would be a real tribute to the fine work which Mr. Keys did, not only for pharmacy but also for medicine, if something of lasting value can come from the series of conferences which he helped to originate.

THE GOVERNMENT CAN SUPPLY SOME NEEDS, BUT NOT ALL

A recent survey conducted by the psychiatry and neurology division of the Veterans Administration disclosed that about a third of the mental patients in V. A. hospitals had been visited by neither family nor friends for a year or more. The report states that while visitors might be disturbing in some instances, they would be highly beneficial in the majority of cases.

The survey uncovered many cases of veterans whose families refused to accept them back home when medical discharge was indicated.

Without being facetious on such a pathetic theme, it does not seem out of place to point up an underlying moral. Here are cases in which the Government (and justly so) has gone all out to provide the best in medical service to men who highly deserve it. Yet there probably are not more than a few of the more than 14,000 who would not gladly exchange their lot for the most humble existence in family or community life.

Few of these men likely will join in reciting the psalm of the bureaucrats, "The State is my shepherd, I shall not want."

PROFOUND WORDS BY MR. BRANNAN

According to the *Washington (D. C.) Evening Star*, the following passage from a recent report of Secretary of Agriculture Brannan (genius behind the socialistic Brannan farm plan) should be engraved in marble or other lasting stone and placed above the main portal of the Department of Agriculture's fine building:

"**Experience with potatoes and with eggs shows that it is much easier to buy than to sell.**"

This emotional eloquence and these profound words (sic) are not too difficult to understand after a look at the scrambled-egg and mashed-potato methods of financing now employed by the group with which Mr. Brannan is associated and which is guiding the economic destiny of the country.

IT USUALLY TAKES MORE THAN IT GIVES

Newsweek says that Paul L. Styles, new member of the National Labor Relations Board, has hung a picture of the late Samuel Gompers, onetime head of the A. F. of L., on his office wall along with this Gompers' quotation: "What the government gives you, the government can take away, and once it starts taking away, it can take more than it gave."

It's about time this quotation received nation-wide circulation, not only among the rank and file of labor organizations, but among plenty of other citizens who are making it a habit of extending an itching palm toward Washington.

Washington Roundup . . .

News and Developments on Proposed Medical and Health Legislation Now Before Congress; Other Events of Interest in Nation's Capital

ALTHOUGH Congress is beginning to look toward adjournment so members can get home to build up political fences, some hot medical and health proposals continue to hold the spotlight.

The following news on the status of pending bills and on other events and developments in Washington is taken from recent bulletins issued by the Washington Office of the American Medical Association.

American Medical Association is moving into the windup months of Congress with its contact and legislative work up to date. In four days of conferences and meetings in Washington, leaders of the association reviewed legislation introduced in the last two months, talked with Representatives and Senators and generally appraised Washington developments.

For their sessions, 20 A. M. A. leaders met for the first time in the Association's new Washington offices, located across L street from the Statler Hotel.

AID TO MEDICAL EDUCATION

The Easter House recess delayed Committee work on Federal Aid to Medical Education (H. R. 5940). The House Interstate and Foreign Commerce Committee got started in executive session on the medical education bill, but had to sidetrack it temporarily. The full Committee is trying to decide whether to go along with a subcommittee's recommendations, one of which gives the council authority over the Surgeon General in approving grants. Other recommended changes are:

Schools of sanitary engineering would become eligible.

Scholarship provisions to be dropped from the bill (except nursing).

The Surgeon General would allocate funds among the several classes of schools only after approval of the National Council on Education for Health Professions. In original bill the Council merely advised. If the appropriations are not sufficient, the amount paid for each student would be uniformly reduced.

A revised provision cuts the total Federal payment to any school (except schools of nursing) from 40 per cent to 30 per cent of the school's annual cost of instruction.

In certifying eligible schools the Surgeon General must follow standards prescribed by the Council. Under the old bill the Council was merely advisory.

Approval of schools of nursing would be left to an agency of the state. The original bill gave the Surgeon General such power.

A new provision authorizes the Surgeon General, in determining whether to make a construction grant and arriving at the amount, to give consideration to the ability of the applicant to defray the cost of the contemplated construction and equipment without receiving assistance from the government. Such grants could not be in excess of 50 per cent or less than 33-1/3 per cent of the cost of such construction or equipment. Not more than 25 per cent of such funds for construction may be allotted to schools and facilities within any one state.

Schools applying for assistance for construction and equipment would be approved or accredited by a recognized body or bodies approved for the purpose by the Surgeon General in accordance with general standards prescribed by the Council.

A revised section provides that if a school within ten years fails to carry out its full construction and equipment commitments, the U. S. shall be entitled to recover its contribution less depreciation.

The section safeguarding schools against Federal control has been rewritten and prohibits interference in the control of personnel or curriculum.

SCIENCE FOUNDATION

Concession by both House and Senate members of the conference committee has speeded up progress of the National Science Foundation Bill (S. 247). First House members backed down on the strict security requirements. One House amendment had required that the F. B. I. itself rule on candidates for Foundation employment or scholarships, rather than merely report the facts without recommendations, the usual F. B. I. responsibility. Instead conferees agreed informally on the following system for clearance: 1. An F. B. I. report without recommendation on all persons who would have access to information on national security. 2. For persons having access to "classified" information, clearance would be the same as for Atomic Energy Commission or military service. 3. Where the employee would not have access to "classified" or security information, the standard government loyalty oath would suffice. After this—the most controversial point—had been argued out, the Senators accepted House restrictions on amount of money to be spent by the Foundation. This means the Foundation will have half a million dollars the first year while it is being organized. Then its spending will work up to an eventual limit of $15,000,000 annually.

HUNT INSURANCE MEASURE

Senate Labor and Public Welfare Committee hearings on Senator Hunt's National Health Insurance Bill (S. 2940) and Senator Humphrey's bill to assist co-op and non-profit health insur-

ance associations (S. 1805) both have been shoved back. The plan now is to take testimony from just one witness on S. 2940, Senator Hunt himself. The Wyoming Senator-dentist, who has done considerable lecturing on health problems in the last few months, says he finds the public more concerned about the cost of hospital care than doctors' charges.

Hearings on S. 1805 will be held May 9 and 10, A representative of A. M. A. will testify in opposition to this bill.

V. A. SQUABBLE

Veterans Administration personnel reductions are creating a confusing situation in the medical department. However, no physicians, dentists or nurses have been given notice, and none will be until V. A. gets a hard and fast decision from Congress as to how much money it will have available, both in deficiency appropriations and in appropriations for the next fiscal year. It is reported that V. A. called off the professional personnel reductions only after getting informal assurance that it would receive enough money to keep all currently employed physicians, dentists and nurses on the payroll.

MILITARY HOSPITAL CUTBACK ROW

The House Armed Services Subcommittee which investigated military hospital cutbacks has asked Defense Secretary Johnson to again review the conflicting arguments. After open hearings in Washington and two inspection trips the Committee was faced with two sets of testimony, so far apart factually that no recommendations could be made. Meanwhile, the hospital reduction program moves ahead as scheduled, under Dr. Richard Meiling, director of the Office of Medical Services, formerly of Columbus, Ohio.

Some background on the Defense Department's hospital cutback program may help to explain the charges and counter-charges now out in public. After the cutback program was drawn up, the three surgeons general were asked their views, Major Gen. R. W. Bliss (Army), Rear Adm. C. A. Swanson (Navy) and Major Gen. Harry G. Armstrong (Air Force). Present at this meeting of the Military Medical Council, in addition to these three officers, were Dr. Meiling, Rear Admiral Joel T. Boone, top military man directly under Dr. Meiling, and Secretary Johnson.

Gen. Armstrong accepted the program and supported it from there on. Gen. Bliss, Adm. Swanson and Gen. Armstrong were asked to talk it over and come back with any suggestions. Their first counter-proposal was rejected by Secretary Johnson because he considered the savings insufficient. They returned with a second proposal, under which five, not 12, general hospitals would be closed, and 13 other hospitals

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would be reduced in status. This was approved, and it was this plan which was announced. When protests started, Chairman Carl Vinson of the House Armed Services Committee decided to investigate.

PLANS FOR CHANGES

The flare-up over closing of hospitals is not the last word on the subject of Defense Department economies. Another series of tightening-up moves is in the making. Some will be aimed strictly at saving dollars, but others will have no direct relation to economy but to produce an orderly, efficient service.

Here is the general shape of reorganization plans in Defense military services:

Regardless what comes of the House hearings, hospitals and other facilities will be reduced in status or closed when they no longer can be justified under an integrated program—Army, Navy and Air Force.

When Dr. Meiling took office last October, the services were staffing 46,281 beds for patients, which he described as "16,000 beds in excess of patient requirements." In addition, Dr. Meiling reports that the services had 50,000 "bed spaces" in facilities which were not staffed. Since then there have been a number of reductions and cutbacks.

Meanwhile, the Department is making a long-range study of its hospitals, preparatory to replacing semi-permanent structures on an orderly priority schedule. The hope is to arrive at a single general pattern for the three services and to decide on the same type facilities. One proposal is to have each new installation, regardless of size, capable of 100 per cent expansion.

Recruitment of doctors will continue. But the total number of doctors on active duty might even be reduced. Secretary Johnson has been informed that the essential problem is not how to obtain more doctors, but how to utilize properly approximately the present number.

These are Defense Department figures on medical manpower: Total operational requirements of physicians for the three services, 5,639. Total physicians available for operational use, 3,982, plus 1,590 interns, residents and civilian doctors in military hospitals. The grand total of these is just 67 short of operational requirements —5,639. Another 1,206 military medical officers —interns and residents—are serving in civilian hospitals and therefore not available for treating military personnel. The total of all physicians in active military service and serving in all capacities is 7,216.

A committee now is at work on the whole question of internships and residencies. It is seeking some system under which the three services could use these officers more efficiently as well as more economically.

There is some question within the Defense Department whether the civilian consultant program is run as efficiently and economically as it might be. In the last full year the three services hired 1,931 physicians on a consultant fee basis. Another committee is studying this question, attempting particularly to devise an appointment system which could be used by all three services and a practical method for joint utilization of the consultants.

Defense Department is making an analysis of the manner in which the three services calculate their medical personnel requirements—how they determine the number of doctors each needs and their distribution. At present three different systems are used; the hope is that a common formula can be found.

A report, now under preparation, will attempt to solve the problem of the medical reserves. Dr. Meiling's office believes the present reserve program is dangerously inadequate, both as to numbers and as to type of training schedules. He is anxious to get more officers to participate in reserve activities and to develop programs which will keep the men and units in maximum readiness.

CIVIL DEFENSE PROGRAM

Working with A. M. A., the National Security Resources Board is getting into outline form a program that will fully integrate medical and health services in civil defense plans. Dr. Norvin Kiefer, the board's medical director, will announce details shortly.

Reassuring testimony was scarce when representatives of four large American cities testified before the Joint Atomic Energy Committee, which is trying to determine the state of the nation's preparedness for atomic attack.

On the medical phase, witnesses generally brought out that any planning would have to be done regionally and nationally, to insure prompt movement into a bombed area of medical supplies and personnel. They emphasized that little reliance can be placed on availability of purely local supplies and personnel, because of the destructive nature of an atomic attack and subsequent confusion and disruption.

Dr. Kiefer was no more reassuring than the city officials. He said board studies had established that in event of heavy civilian casualties, the health services definitely would be inadequate. He warned that in such an emergency, health personnel, supplies and hospital facilities could not do the job demanded. Dr. Kiefer said the Federal government was looking toward regional stockpiling of supplies. He advised communities to inventory all local personnel and supplies. Dr. Kiefer also discussed progress toward establishment of a national organization which could handle the various problems of blood procurement. He said, "The only recourse is a highly efficient organization—including a huge reserve of standard bottles and other supplies—ready to stage a mass blood procurement from persons outside the attacked area."

MISCELLANEOUS

Public Health Services get 69 million dollars more than it has this year but 34 million less than it asked in the lump-sum appropriation bill. The Appropriations Committee made the changes. The Committee recommended a total of $269,-500,000 for P. H. S., which may go up or down depending on action of House and Senate.

A major reduction came in appropriations to

carry on the Hill-Burton Hospital Construction Act, which was cut in half to 75 million dollars.

* * *

Over the past 25 months, U. S. has approved grants of $210,000,000 toward construction of 1,019 hospitals and health centers under the Hill-Burton Act; total cost of the projects is more than half a billion dollars, with the difference financed by state, local and private institutions. Only 139 of the institutions are in operation now, the remainder under construction or in the blueprint stage.

* * *

More delay is in prospect for the school health services bill (S. 1411), which A. M. A. opposes because of one provision—the grant of authority to treat all children regardless of parents' ability to pay. The school health bill is awaiting action by the House Interstate and Foreign Commerce Committee. Meanwhile, the House Education Labor Committee is involved in discussing the general school aid bill (S. 246). Two issues still are not resolved: 1. Does this bill open the way to an undesirable amount of Federal control of schools? 2. Shall private and religious schools be eligible for assistance along with public schools? The second point is not an issue in the health bill, but the question of Federal controls is. It may be found desirable to consider the bills together in the House. If this is the plan, action on school health will be held up until the most controversial sections of the general aid bill have been argued out in Committee. At any event, the close relationship between the two bills does not make for fast action on school health.

* * *

Grass-roots appeals, from physicians and the public, are one explanation of why a House Committee added two and one-half million dollars to an appropriation for research into cortisone and ACTH. The House Appropriations Committee boosted a requested appropriation for National Institutes of Health from $1,100,000 to $3,600,000. However, there is almost no possibility that these substances will be available for general treatment in the near future because the supply is scarce and the cost very high.

* * *

Congress is being urged to increase appropriations for mental health from a budgeted 9.9 millions dollars to 26 million. The request, made before a Senate subcommittee, came from two representatives of the National Committee for Mental Hygiene, who were seconded by two other witnesses.

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Do You Know? . . .

Dr. Charles L. Hudson, Cleveland, presented the viewpoint of the medical profession in a panel discussion of National Health Insurance sponsored by the Wayne County Community Forum, April 12, at Wooster.

* * *

The role of the medical profession in guiding school health programs was discussed by Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, at a combined meeting of the Highland County Tuberculosis and Health Association and other groups interested in school and community health, at Hillsboro, March 29. Other speakers included Dr. Paul Q. Peterson, Assistant State Director of Health, and Paul E. Landis of the State Department of Education.

* * *

Dr. C. W. Waggoner, Toledo, has been reappointed by Governor Frank J. Lausche to membership on the State Medical Board, for a term ending March 18, 1957.

* * *

Members of the University of Cincinnati College of Medicine Alumni Association presented Dr. Martin H. Fischer, professor of physiology, with a gold cigaret case and a check for $600 at the annual University of Cincinnati Founder's Day dinner, April 4. Dr. Fischer will retire this year after 40 years of service to the school.

* * *

Thomas A. Hendricks, secretary of the Council on Medical Service of the American Medical Association, spoke on "Medical Problems of Today," at a public meeting sponsored by the Woman's Auxiliary to the Belmont County Medical Society, March 23, in the Bellaire High School auditorium.

* * *

Dr. J. V. Winans, Madison, aged 85, now in his 63rd year of active medical practice, has been reelected president of the Lake County Board of Health, which he has headed since the board was organized 30 years ago.

* * *

The Ohio County Medical Society, Wheeling, W. Va., now requires payment of A. M. A. dues of $25 for 1950 as a prerequisite to membership in the county society.

* * *

During the recent convention of the American Protestant Hospital Association in Chicago, the Southside Baptist Hospital Association repudiated all forms of government financial aid for hospital construction and operation. The Baptist group described acceptance and use of government funds by a religious denomination or society as "encouragement of the present trend in America toward a socialized state."

Dr. Richard W. Vilter, associate professor of medicine, University of Cincinnati College of Medicine, is one of 80 physicians recently appointed as consultants on nutrition to the U. S. Public Health Service.

* * *

The Council of Pharmacy and Chemistry of the American Medical Association has formed a Committee on Pesticides to study the health problems associated with the use of insecticides, fungicides, rodenticides, herbicides and other forms of economic poisons. Dr. Torald Sollmann, Cleveland, is chairman of the committee.

* * *

Dr. Allan C. Barnes, chairman of the Department of Obstetrics and Gynecology, Ohio State University College of Medicine, was guest speaker at a meeting of the Louisville, Ky., Obstetrics and Gynecology Society, March 27.

* * *

Mrs. Erma Drayer Marting, wife of Dr. W. F. Marting, Ironton, has been named Ohio Mother of 1950 in a state-wide competition sponsored by the Woman's Forum of Cleveland. The Martings have three daughters who are physicians—Dr. Esther Fabing, Cincinnati; Dr. Anne Alstott and Dr. Miriam Marting, Ironton.

* * *

Dr. Phillip T. Knies, Columbus, associate professor of clinical medicine, Ohio State University College of Medicine, will be the delegate of the Ohio State Medical Association to the decennial meeting of The United States Pharmacopoeial Convention, May 9-10, at Washington, D. C.

* * *

The American Physicians Art Association will hold its twelfth art exhibition in conjunction with the American Medical Association meeting at San Francisco, June 26-30. For details and entry blanks, write the secretary, Dr. F. H. Redewill, 525 Flood Bldg., San Francisco 2.

* * *

Dr. Marion A. Blankenhorn, professor of medicine, University of Cincinnati College of Medicine, was one of the guest speakers at an interstate medical meeting held at the Greenbrier, White Sulphur Springs, W. Va., March 29. Dr. Blankenhorn spoke on "The Specificity of the Vitamins and Their Proper Clinical Use."

* * *

Approximately $72,000,000, about $110 per patient, was spent by the City of New York for patient care administered through its municipal hospitals during 1949. Of those treated, 275,000 were in-patients, 377,500 were cared for in clinics and 2,500 received home care, according to the annual report of the Bureau of Administration of the City's Department of Hospitals.

Health Department Sets Up Five District Consulting Offices

The Ohio Department of Health is setting up five district offices in the State in order to decentralize its consultation services, Dr. John D. Porterfield, director, announced.

Four of these district offices have been selected as follows: Southeast district, Athens; northeast district, Cuyahoga Falls; northwest district, Bowling Green; central district, Delaware. An office for the southwest district had not been announced at the time of this writing.

In announcing the new development, Dr. Porterfield said: "It was decided to increase the consultation services available to local health departments in line with the Ohio Department's basic objective of establishing at least minimum standards of service and to provide all possible assistance to local health departments in meeting standards."

The director further explained that for years consultation service has consisted of aid in public health nursing and sanitary engineering, but that personnel had to impose upon local health departments for space and facilities.

Ultimate goal of the Department is to staff district offices with medical officers, engineering and sanitation consultants, public health nursing consultants, health education consultants, records and administrative consultants or personnel for any other special assistance which might be needed.

No direct services will be rendered through district offices. Their functions will be purely that of consulting with local health departments, Dr. Porterfield stressed.

Unemployment Compensation

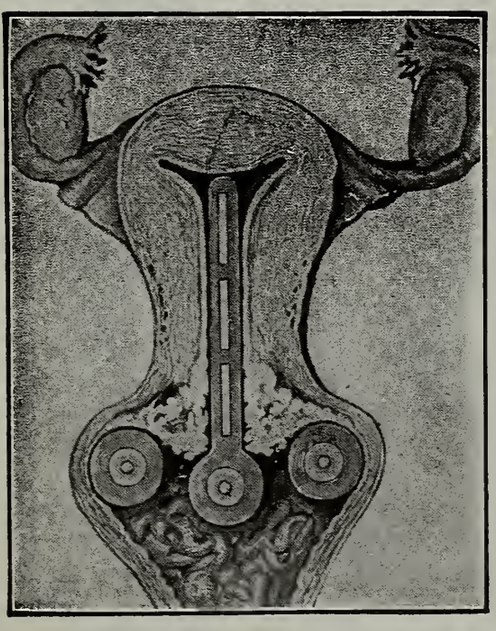
Leaving Ohio for reasons of health does not necessarily disqualify a person from drawing unemployment compensation if he can prove that he is actively seeking a job after he recovers and is able to work.

That was the decision of the Bureau of Unemployment Compensation's Board of Review on the claim of a former Cincinnati worker who applied for benefits in Arizona where he had gone on the advice of his physician.

With one member dissenting, the Board's decision reversed the B. U. C. administrator's initial determination in which the claim was disallowed on grounds that the claimant was on sick leave and was not available for work.

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Shots at Truman-Ewing Compulsory Sickness Insurance Scheme; Ammunition For Doctors in Speeches Against Federalized Medicine

"The British National Health Service, which provides medical, hospital, and dental care, as well as medicines and appliances, to all persons in the country, is financed mainly from general taxation, but slightly more than one-tenth of the employer-employee contribution for national insurance goes to the health services. These contributions meet at this time about one-ninth of the cost of the National Health Service."—*Social Security Bulletin, March, 1950, Page 4.*

* * *

"Before it is too late, before we have too many on unemployment insurance, socialized medicine, too many looking to the government for support, we had better step back, survey our future and start working towards a return to individual initiative, incentive for development of local resources, and less Federal control in local activities."—*Williamsburg, Ohio, Times.*

* * *

"This process through which people slowly sell their control over their own earnings and savings is inherent in the welfare state. And it is fostered, of course, by the Socialist doctrine that the state is better able to spend the people's money than they are themselves."—*Raymond Moley in the Columbus Dispatch.*

* * *

"To put the matter quite bluntly, the Administration (compulsory health insurance) plan is a phony. It would not even begin to do what its political sponsors say."—*The Cincinnati Times-Star.*

* * *

"Too many people in this country are blind to the pitfalls of government control and are wont to pattern after European countries whose standard of living is not as good nor ever will approach the American people."—*Freeport, Ohio, Press.*

* * *

"Now, it is said that the Russians are going to purge the doctors and medical investigators. They are accused of accepting the doctrines of Pasteur and the German pathologist Rudolf Virchow. They must, says the Kremlin, disavow such abominable ideas and accept the medical theories of Marx, Lenin, and presumably, Stalin." —*Marietta Times.*

"Pointing out that in England a movement already is under way to have the government provide legal services, Gallagher advised his audience that 'preventive law is just as important as preventive medicine.' "—*Address of Harold J. Gallagher, president of the American Bar Association before Cleveland Bar Association, as reported by The Cleveland Press.*

* * *

"They—the patients—are beginning to see the fallacies of the scheme, and they are going to take it out of someone. That someone is going to be us, as it has always been intended that it should be. There will come the final destruction of our traditional medicine. The doctor-patient relationship will have gone, and gone for many generations, if not forever."—*Ronald I. Bence, of Birmingham, England, in the British Medical Journal.*

* * *

"People must stand up and be counted on issues of the day or else be counted out in the final analysis and eventually become shackled by a socialist government. People should voice their opinions by voting and writing letters to their senators and congressmen, telling them how they feel about things."—*Robert Wallace, Pittsburgh, district manager, Lilly Pharmaceutical Co., addressing Steubenville Lions Club.*

* * *

"In the absence of violent revolution, socialism isn't something that happens to a country over night. It has small beginnings, a suggestion here, a regulation there, a slight addition to the powers of government, all of which combined eventually to government control over the lives of everyone. And it is never called socialism. It is disguised under the name of government planning."—*Cleveland Plain Dealer.*

* * *

"The other day I heard a discussion of socialized medicine. It was a plea for retention at least of the personal relationship between doctor and patient, and in support of that plea the speaker remarked that the collective conscience had never equaled the individual conscience in awareness of right and wrong . . . and that is perhaps the best reason I have heard why Jefferson was right in holding the best government governs least."—*Wes Lawrence in the Cleveland Plain Dealer.*

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1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

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In Memoriam . . .

Henry Renick Brown, M. D., Chillicothe; University of Michigan Medical School, 1901; aged 71; died April 4; member of the Ohio State Medical Association; member of the American Medical Association; vice-president of the Ross County Medical Society, 1932-33. Dr. Brown had practiced medicine in Chillicothe for 47 years. In addition to his professional work, he was active in many community affairs; was a past-president of the Rotary Club and vice-president of the city Board of Health on which he had served since 1932; was a member of the Episcopal Church and several Masonic orders. He was a veteran of World War I. Surviving are his widow, two sons, one of whom is Dr. Henry A. Brown of San Mateo, Calif., and two daughters.

Elber Robert Brubaker, M. D., Springfield; Medical College of Ohio, Cincinnati, 1908; aged 65; died April 4; member of the Ohio State Medical Association and a Fellow of the American Medical Association; member of the Radiological Society of North America, Inc. Dr. Brubaker had practiced medicine in Springfield for approximately 40 years where he was active in other community activities. He was a veteran of both World Wars, having served as an Army medical officer during I and as a Navy medical recruiting officer during II. He was a member of the Masonic Lodge, the Elks Lodge, the Last Man's Club, the American Legion, the Methodist Church and the Springfield Farmers' Club. Surviving are his widow and two sisters.

William Dean Collier, M. D., Youngstown; Johns Hopkins University School of Medicine, Baltimore, 1924; aged 53; died March 15; member of the Ohio State Medical Association and a Fellow of the American Medical Association; member of the American Association of Pathologists and Bacteriologists and the American Society of Clinical Pathologists. Dr. Collier moved his practice from St. Louis in 1939 to Youngstown where he was pathologist at St. Elizabeth Hospital. In St. Louis he was on the faculty of St. Louis University School of Medicine. He was a member of Sigma Xi. A sister survives.

Preston Wiley Fishbaugh, M. D., Mendon; College of Physicians and Surgeons of Baltimore, 1893; aged 86; died March 25; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1945; president of the Mercer County Medical Society, 1932-34; chairman of the Defense and Legislative Committee of the Society in 1944. Dr. Fishbaugh had been active in practice in Mendon from 1893 until his retirement in 1940. Recently he was presented the 50-Year Pin and Certificate of the Ohio State Medical Association. He was a member of the Methodist Church. Surviving are his widow, one son and two daughters.

Desider Foldes, M. D., Cleveland; Royal Hungarian University, Budapest, 1905; aged 69; died March 27; member of the Ohio State Medical Association and a Fellow of the American Medical Association; member of the American College of Surgeons. Dr. Foldes began his practice in Cleveland in 1914.

Frederick William Gross, M. D., Madisonville; University of Cincinnati College of Medicine, 1935; aged 40; died March 21; member of the Ohio State Medical Association and the American Medical Association. Dr. Gross had practiced in Madisonville for about 15 years. Surviving are his widow, two children and his parents.

Elliott Miley Hendricks, M. D., Fort Lauderdale, Fla.; University of Cincinnati College of Medicine, 1922; aged 53; died March 7; former member of the Ohio State Medical Association through 1926; listed in the A. M. A. Directory as a member of the Florida Medical Association and a Fellow of the American Medical Association. Surviving are his widow, a daughter, three brothers including Dr. Louis J. Hendricks, of Cincinnati, and Dr. Anthony B. Hendricks, of Biloxi, Miss., a sister and his step-father.

Henry Demuth Jackson, M. D., Circleville; Ohio State University College of Medicine, 1911; aged 66; died March 23; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Pickaway County Medical Society for several terms including 1950 and vice-president for a number of terms; treasurer for the year 1930, and delegate to the Ohio State Medical Association for several terms. Dr. Jackson served his entire professional career in Circleville with the exception of time he was in military service. During World War I he served as a major, and later was advanced to the rank of colonel as a medical officer in the Ohio National Guard. He served also as a medical officer during World War II. Active also in many community affairs, he served for many years on the city board of health, was a member of the Presbyterian Church and held many offices in the Masonic Lodge and in the Elks Lodge. Surviving are his widow, one daughter and one son.

John Donovan Kessler, M. D., Coolville; University of Pennsylvania School of Medicine, Philadelphia, 1912; aged 61; died April 2; former member of the Ohio State Medical Association and the American Medical Association through 1937. Dr. Kessler moved his practice to Coolville 12 years ago from Columbus where he also practiced for many years. Surviving are his widow, a son, a daughter and a sister.

Harold Levi Lawrence, M. D., Canton; Ohio State University College of Medicine, 1931; aged 47; died March 12; former member of the Ohio State Medical Association and the American Medical Association through 1947. Dr. Lawrence was chief medical officer for the Veterans Administration office in Canton. He previously spent a number of years in public health work and several years in Europe as a medical officer on diplomatic service. Surviving are his widow and two brothers.

Alfred Lewin, M. D., Piqua; Friedrich-Wilhelms University Medical School, Berlin, 1913; aged 63; died March 24. Dr. Lewin came to the United States 13 years ago and practiced for 10 years in Piqua. Surviving are his widow and a daughter.

Lora Larason Marriott, M. D., Newark; Physio-Medical College of Indiana, Indianapolis, 1896; aged 80; died March 25; former member of the Ohio State Medical Association and the American Medical Association through 1939. Dr. Marriott practiced medicine in Licking County from 1896 until 1917 when he went into the Army. After World War I, he served with the Veterans Administration. Upon his retirement in 1939 he returned to Newark. Surviving are his widow, a brother and two sisters.

Esther M. Mast, M. D., Mansfield; University of Rochester School of Medicine, New York, 1931; aged 46; died March 17; member of the Ohio State Medical Association and the American Medical Association; member of the American Trudeau Society and the American College of Chest Physicians. Dr. Mast practiced for a number of years in Mansfield where she was on the active staff of the Mansfield General Hospital. She was co-author of *Fundamentals of Nutrition* published in 1939. Surviving are her husband, Dr. Earl C. Mast, of Mansfield, a son, a daughter, two brothers and a sister.

Frederick Roy McVay, M. D., Botkins; Medical College of Ohio, Cincinnati, 1909; aged 67; died March 25 while on a trip in Florida; member of the Ohio State Medical Association and a Fellow of the American Medical Association; vice-president of the Shelby County Medical Society in 1926; its secretary in 1943 and president in 1944. Dr. McVay had practiced his profession in Botkins and vicinity for 40 years. He was a member of the Methodist Church and several Masonic orders. Surviving are his widow and a sister.

Lawrence Delano Miller, M. D., Toledo; Eclectic Medical College, Cincinnati, 1915; aged 57; died March 18; member of the Ohio State Medical Association and a Fellow of the American Medical Association; delegate of the Academy of Medicine of Toledo to the Ohio State Medical Association, 1942-43. Dr. Miller had practiced in Toledo for 33 years, where he was director of the Urological Clinic of the Toledo State Hospital for 23 years and on the staff of other hospitals. He was a member of the Methodist Church, several Masonic orders, past-president of the Kiwanis Club, and a veteran of World War I. Surviving are his widow, two daughters, a sister and a brother.

George Elliott Peters, M. D., Columbus; Ohio State University College of Medicine, 1927; aged 55; died March 24; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Peters had served his entire professional career in Columbus, where he was director of surgery at Mercy Hospital. A veteran of World War I, he was a member of the American Legion, and held membership in the Elks Lodge, the Columbus Athletic Club and the Columbus Maennerchor. Surviving are his widow, a son, two daughters, his mother and a sister.

William A. Ray, M. D., Portsmouth; Medical College of Ohio, Cincinnati, 1897; aged 76; died March 24; member of the Ohio State Medical Association and the American Medical Association; president of the Hempstead Academy of Medicine, 1920, and its vice-president in 1933. Dr. Ray had practiced in Portsmouth beginning in 1918. He recently was honored by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. He was active in several Masonic orders. Surviving are his widow and a son.

William Thomas Shipe, M. D., Middletown; Baltimore Medical College, 1894; aged 83; died March 13 at the Veterans Administration Hospital, Augusta, Ga., where he had been for six years; former member of the Ohio State Medical Association and the American Medical Association through 1939. Dr. Shipe had practiced his profession in Middletown for many years before retiring several years ago. He served in the Medical Corps during World War I.

Daniel Webster Shumaker, M. D., Dover; Ohio Medical University, Columbus, 1898; aged 80; died March 28; member of the Ohio State Medical Association and the American Medical Association; president of the Tuscarawas County Medical Society in 1938; member of the American College of Surgeons. Dr. Shumaker had practiced his profession for 52 years—43 years in Dover. Recently he was honored by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. In 1940 he was awarded the degree of doctor of humane letters by Mount Union College. He was a charter member and past-president of the Dover Kiwanis Club and a member of the Lutheran Church. Surviving are three daughters and a son.

Charles Herbert Spencer, M. D., Bowling Green; Chicago Homeopathic Medical College, 1898;

aged 74; died March 4. Dr. Spencer practiced for short periods at Lucas, Carey, Bowling Green and Cleveland, and for many years was in the pharmaceutical business. Surviving are his widow, a son, a daughter, a sister and a brother.

Joseph J. T. Sweeney, M. D., Toledo; Jefferson Medical College of Philadelphia, 1911; aged 65; died March 16; member of the Ohio State Medical Association and the American Medical Association. A native of Toledo, Dr. Sweeney served his entire professional career there. In addition to his medical practice, he took an avid interest in public affairs, especially athletics. For 18 years he served as physician for the Toledo Baseball Club; he served also as boxing commissioner and in other official capacities in sporting events. He was a member of the Catholic Church and the Kiwanis Club. Surviving are his widow, two sons and two daughters.

Lester Taylor, M. D., Cleveland; Johns Hopkins University School of Medicine, 1910; aged 65; died April 11 while vacationing in North Carolina; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Cleveland Academy of Medicine, 1935; its vice-president, 1934; secretary-treasurer, 1920-22; delegate, 1936; served as member and chairman of numerous Academy committees; member of the Board of Directors, 1928-37; diplomate of the American Board of Internal Medicine. Dr. Taylor began his practice in Cleveland upon completion of his education. He was founder of the Cleveland Health Museum and its president from the time of its founding in 1936 until his death. During World War I he served as a major in the Army Medical Corps in Europe, and during World War II served on a local draft board. His widow and a sister survive.

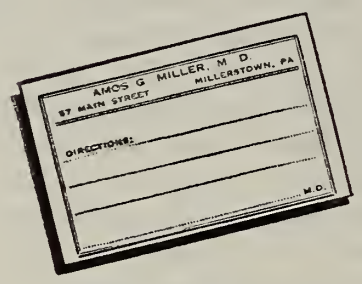
Anderson L. Troy, M. D., Springfield; Miami Medical College, Cincinnati, 1904; aged 77; died March 20. A resident of Springfield for 14 years, Dr. Troy had retired from active practice several years ago. Survivors include his widow, a daughter and two sisters.

Gerard Thomas Willke, M. D., Cincinnati; University of Cincinnati College of Medicine, 1921; aged 53; died April 3; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Willke began his practice in Maria Stein where he succeeded his father, the late Dr. A. J. Willke, and moved to Cincinnati in 1935, after directing Kneipp Sanatorium, Rome City, Ind., for five years. He was a member of College Hill Civic Association, College Hill Business Men's Association, and the Catholic Church. Surviving are his widow, four daughters, two sons, one of whom is Dr. John C. Willke of Cincinnati; five sisters, and two brothers, Dr. Edgar J. Willke, Maria Stein, and Dr. Alois H. Willke, Cincinnati.



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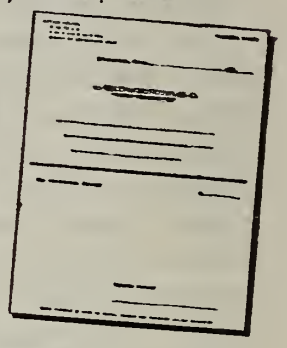
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Buckeye News Notes . . .

Ashland—Dr. H. M. Gunn discussed "Medical Aspects of the Atomic Bomb" before the Ashland Lions club at a recent meeting.

Bedford—"Socialized Medicine From a Doctor's Point of View" was the topic discussed by Dr. Iredell M. Hinnant, Cleveland, before the Bedford Kiwanis Club.

Chillicothe—"Community Pill Mills" was the title of a talk by Dr. Edwin H. Artman before the Kiwanis Club. The title was the speaker's characterization of proposed socialized medicine. He also discussed "Socialized Medicine" before the Rotary Club.

Chillicothe—Dr. Ralph W. Holmes discussed the influence of Rotary on legislation affecting crippled children before the Chillicothe Rotary Club.

Cincinnati—Dr. Stanley E. Dorst, dean of the University of Cincinnati College of Medicine, was reelected president of the Heart Council of the Public Health Federation. Other officers are Dr. Charles Maertz, vice-president, and Dr. Floyd P. Allen, treasurer and executive secretary.

Cleveland—Dr. Douglas D. Bond, of the Western Reserve University School of Medicine, appeared before a Senate committee in Washington in behalf of appropriations of Federal funds to train more people in the field of mental illness.

Columbus—Dr. Roger M. Gove, Piqua, has been appointed superintendent of the Columbus State School effective April 1. Dr. F. L. Keiser recently resigned from the position.

Columbus—Dr. W. D. Inglis has been named an honorary life member on the Board of Directors of the Friendship House, a community project with which he has worked since its organization in 1911.

Elyria—Dr. Robert H. Browning, Oberlin, was guest speaker at the Elyria Chapter meeting of the National Council of Catholic Nurses. His topic was "The Chest."

Elyria—Dr. Marion G. Fisher, Lorain County health commissioner, was speaker at the meeting of the Elyria Business and Professional Women's Club. He explained the work of the health department.

Fostoria—Dr. Thomas W. Geoghegan spoke on "Preventive Medicine" before the Whittier P.-T. A.

Fostoria—Dr. Emmerich von Haam, Ohio State University College of Medicine, Columbus, conducted the regular monthly clinical and pathological conference of the Fostoria Medical Society. Dr. William F. Yarris, president of the society, presided.

Fremont—Dr. John J. Gedert of Clyde has been designated by the Sandusky County Tuberculosis and Health Association to assume charge of monthly chest clinics at Fremont Memorial Hospital.

Grove City—Dr. Gilman D. Kirk, Columbus, spoke on "Socialized Medicine" before the Grove City Lions Club.

Hillsboro—Dr. J. Martin Byers, Greenfield, was named to the Highland County Board of Health for a one-year term to fill the unexpired term of Dr. W. H. Willson, Greenfield, who resigned.

Lisbon—Dr. Chester W. Dewalt, Columbiana, was reelected to the Columbiana County Board of Health. Dr. Robert M. Dunlap is county health commissioner.

Navarre—Dr. C. S. Palmer, Massillon, discussed "Socialized Medicine" at a dinner meeting of the King's Club, Inc., held at the Bolivia Evangelical and Reformed Church.

Painesville—Dr. J. M. York has been named medical director of the Diamond Alkali Company's plant in Painesville. He is continuing his private practice also.

Piqua—Dr. George A. Woodhouse, Pleasant Hill, addressed Piqua and Miami County Legionnaires on the subject, "Federal Health Insurance."

St. Marys—Dr. W. V. Barton spoke on the subject of health before the Parent-Teachers Association.

Salem—Dr. Paul Q. Peterson, assistant director, Ohio Department of Health, Columbus, was guest speaker at a recent meeting of the Salem Rotary Club.

Salem—Dr. Lea A. Cobbs was elected president of the Columbiana County Public Health League at its annual meeting.

Salem—Dr. Lewis K. Reed, Youngstown, spoke of the detection and treatment of heart diseases before the local Kiwanis Club. Dr. Richard McConnor was program chairman.

Toledo—Dr. Foster Myers was a speaker on the weekly broadcasts entitled "Things You Ought To Know," sponsored by the Toledo Public Health Association, over Station WSPD.

Toledo—Dr. Maurice A. Schnitker was principal speaker at the February meeting of the Northwestern Ohio Branch of the American Pharmaceutical Association. His topic was "New Developments in Cardiovascular Disturbances."

Washington C. H.—Dr. J. H. Persinger is chief of staff of the new Fayette County Hospital. Dr. James E. Rose is vice-president and Dr. Hugh W. Payton, Jeffersonville, secretary-treasurer.

Payments for Rabies Cases . . .

Recent Investigation in Cuyahoga County Reveals Claims Settled Unlawfully By Commissioners; Findings Made Against Physicians

THAT there is considerable confusion in the minds of many physicians—perhaps among boards of county commissioners, as well—regarding the existing state law providing for compensation at public expense to persons bitten or injured by a dog, cat or other animal is revealed in a recent investigation made in Cuyahoga County by examiners of the Bureau of Inspection and Supervision of Public Offices, Department of Auditor of State.

The history of the present situation is as follows: Recently the books and records of the Board of County Commisisoners of Cuyahoga County were examined by representatives of the state bureau. They had not been examined since 1946.

FACTS IN CASES

The examiner made certain findings for recovery against the board of commissioners, basing his action on the fact that the provisions of Section 5851 and 5852 of the Ohio General Code had been violated and that approximately 285 claims filed by persons bitten or injured by dogs or other animals had been paid unlawfully.

In practically all of these cases, physicians had been paid for medical care to the claimants although in all cases it had been determined that the animal was not afflicted with rabies. For that reason, the examiner contended that the payments had been made in violation of state law. Subsequently, actions to recover from the physicians the amount paid to them by the county commissioners were instituted.

The two sections of the state law which served as a basis for the recovery action read as follows:

ANIMAL MUST HAVE RABIES

Section 5851—A person bitten or injured by a dog, cat or other animal **afflicted with rabies**, if such injury has caused him to employ medical or surgical treatment or required the expenditure of money, within four months after such injury and at a regular meeting of the county commissioners of the county where such injury was received, may present an itemized account of the expenses incurred and amount paid by him for medical and surgical attendance, verified by his own affidavit and that of his attending physician; or the administrator or executor of a deceased person may present such claim and make such affidavit. If the person so bitten or injured is a minor such affidavit may be made by his parent or guardian.

Section 5852—The county commissioners not later than the third regular meeting, after it is so presented, shall examine such account, and, if found in whole or part correct and just, shall order the payment thereof in whole or in part to the patient and to the physician who rendered such treatment, in accordance with their respective claims, but a person shall not receive for one injury a sum exceeding two hundred dollars.

It should be noted that the law states specifically that the person entitled to compensation must have been bitten or injured by an animal "afflicted with rabies."

WARNING TO PHYSICIANS

Obviously, a physician called to see a person bitten by an animal **should not delay in providing the person with necessary and adequate treatment.** In other words, he should not delay treatment until it has been decided that the animal is afflicted with rabies.

On the other hand, the physician should understand the provisions of the law and should advise the patient of such provisions. Also, he should **make it clear to the patient that the patient is in the first instance responsible for and obligated to pay for the medical services.** If the animal had rabies and the claim is allowed by the commission, then the patient can use the compensation received to pay the physician. There is even some question, due to the wording of Section 5852, whether the commissioners can pay the physician directly.

Nevertheless, the important thing for physicians to remember is that payments by county commissioners to physicians in cases wherein the animal does not have rabies is an unlawful act and that recovery can be made against the commissioners, physicians or claimants receiving such payments.

Eighth District Meeting Scheduled At Rocky Glen June 15

The customary annual spring meeting of the Eighth Councilor District of the Ohio State Medical Association will be held on June 15 at the Rocky Glen Sanatorium at McConnelsville.

An excellent scientific program and the usual congenial get-to-gether are in store for doctors of the area. Dr. Louis Mark and members of his staff at the Sanatorium will be official hosts for the occasion.

A program with further details will be mailed to doctors of the district by the program committee.

X-Ray Technicians Schedule National Meeting in Columbus

The American Society of X-Ray Technicians will hold its 22nd annual convention at the Deshler-Wallick Hotel in Columbus, May 28-June 2. The organization is anticipating an attendance of approximately a thousand persons, including technicians from all the States, Canada and Hawaii.

Refresher courses will include classes conducted by L. G. Idstrom, M. D., Minneapolis, and Darmon A. Rhinehart, M. D., Little Rock, on X-Ray physics; George L. Sackett, M. D., Cleveland; and Grant O. Graves, Columbus, on radiographic anatomy.

Other prominent physicians taking part in the scientific program will be Joseph L. Morton, M. D., Columbus, Robert A. Arens, M. D., Chicago; Maurice D. Frazer, M. D., Lincoln, Neb.; and Robert Reeves, M. D., Durham, N. C. Donald F. Bowers, M. D., Columbus, will be toastmaster at the banquet.

Additional information may be obtained from Genevieve J. Eilert, R. T., executive secretary, 16 Fourteenth St., Fond du Lac, Wisc.

Conference of County Medical Society Officers Scheduled in San Francisco

The Seventh National Conference of County Medical Society Officers will be held in San Francisco on Sunday, June 25, the day prior to the opening of the A. M. A. annual session.

The program is designed as a discussion forum on subjects of particular interest to county medical society officers. All persons attending the conference will be welcomed to participate in discussions.

Two sessions will be held, both at the Palace Hotel—one from 9 a. m. to 12 noon, and another session from 8 p. m. to 9:30 p. m.

The conference is sponsored by the Board of Trustees of the A. M. A. and is designed to help individual county societies.

A feature of the program is entitled "What Do You Know for Sure?" It will be a true and false questionnaire on socialized medicine to be given to everyone in the audience. Results will be announced at the end of the morning session.

Other features of the morning session will be: "How To Set Up a County Medical Society Record System"; How To Organize a Community Health Council"; and "Providing Special Benefits Through County Medical Society Membership."

The evening session includes two discussions. The discussion on the subject, "The Third Party in the Practice of Medicine," refers to insurance companies, hospital and medical care plans, etc. "Hospitals and the Practice of Medicine" will be the topic of a second discussion.

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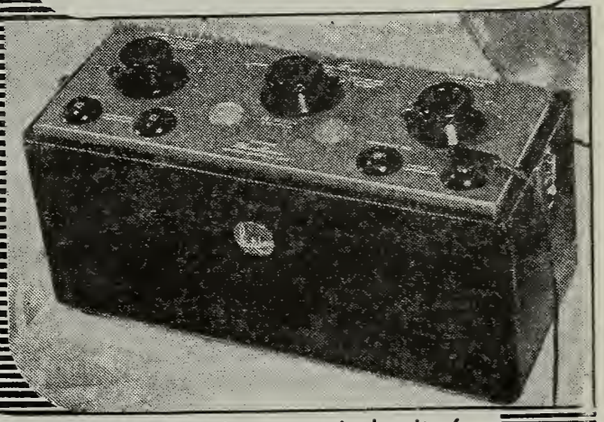
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Communicable Disease Regulations . . .

At a Recent Meeting of the Ohio Public Health Council Part of the Sanitary Code Was Revised, Effective July 1

NEW communicable disease regulations, adopted by the Ohio Public Health Council at a meeting in Columbus on April 8, will replace the current communicable disease regulations in the Ohio Sanitary Code as of July 1, 1950.

Dr. John D. Porterfield, director of the Ohio Department of Health, called attention to the fact that these regulations are a material change from those currently in effect. It has been the intent of the Ohio Department of Health and the Ohio Public Health Council to bring these regulations as close to modern scientific knowledge as possible, he said.

Conferences with qualified epidemiologists and communicable disease specialists over the past six months have contributed heavily to improvement in the regulations. Consideration of the 1950 revised recommendations of the American Public Health Association and current regulations in other states played a part in the revision.

In addition to modernization, Dr. Porterfield pointed out, these regulations have been changed as much as possible in the direction of the least amount of complexity for the private physician, compatible with good communicable disease control.

It is to be noted that the diseases listed as reportable must in all instances be reported by the attending physician to the responsible local health authority.

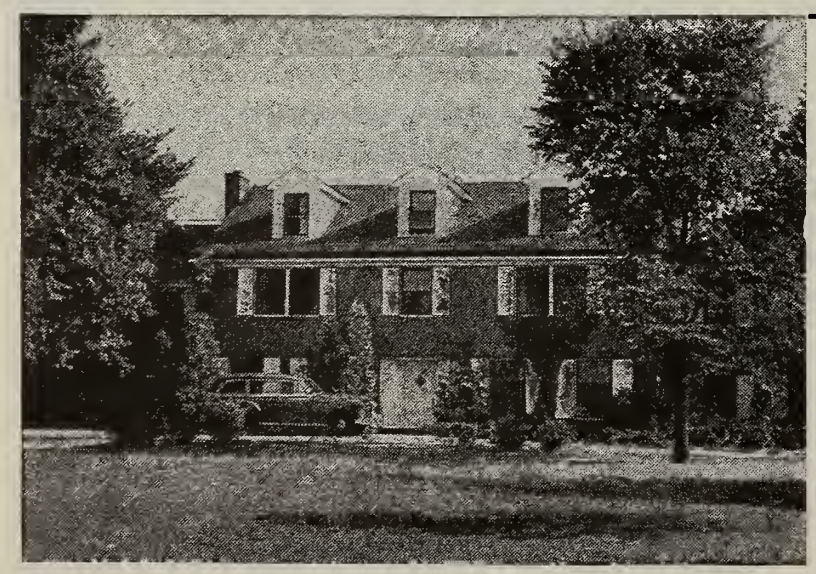
"It is our feeling," Dr. Porterfield continued, "that the best method by which compliance can be obtained is cooperation with and assistance to the practicing physicians. Reporting of communicable diseases in Ohio has been nowhere near complete and it is hoped the new regulations will simplify the requirements to the point where better conformance will follow."

The health director pointed out that communicable disease data are important to communities and to local health departments in enabling them to plan the public health programs most necessary. Such data are important to hospitals and medical people in general in measuring disease incidence and prevalence. They are important to individual physicians in their diagnostic work by indicating the probabilities of various conditions in the individual community.

In regard to cooperation between health officers and private physicians, Dr. Porterfield remarked that it seemed to him a desirable idea that the local health commissioner be requested to report at the local medical society meetings at appropriate intervals on communicable disease incidence and distribution to permit physicians to retain an idea of the total health picture of the community.

"It is finally to be noted that the diseases listed as reportable were selected with considerable attention from the point of requiring reports only in those conditions where collected data would be of use," the health director said. Each disease listed is an actual or potential problem in Ohio, he assured. He concluded by saying that the Health Department will be happy at any time to discuss communicable disease reporting and the best methods of maintaining good cooperative relations between practicing physicians and public health officers.

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Rural Health Committee Approves Lecture Course and Makes Plans for Future Work

Meeting at the State Headquarters Office, Columbus, Sunday, April 2, the Committee on Rural Health of the Ohio State Medical Association approved detailed outlines for a "Lecture Series on General Practice in the Small Community."

The Committee, which met with members of the Committee on Education for consideration of this and similar projects, is selecting lecturers for the series. In the near future it will see the approval of the deans of Ohio's medical schools, for presentation of the series at the three Ohio institutions.

DEANS TO BE CONSULTED

Further study was given to a proposal involving rural externships for medical students, with rural general practitioners. Information on such a plan in Wisconsin was received by the Committee. It was decided that the medical school deans should be consulted about the possibilities of such a plan, and that definite responsibilities of both student and preceptor should be listed, following which the proposal should again be considered by the joint committee and further information be considered regarding the operations of such plans in Oklahoma and Kansas.

The Committee developed and approved plans for a meeting to be sponsored by the Ohio State Medical Association, with interns and residents of Cincinnati and other Southwest Ohio areas as guests. This proposal envisions an afternoon seminar or workship for the interns and residents on economic, legal, ethical and organizational matters of importance to young doctors starting a practice, to be followed by a dinner for the men and their wives.

A July 1 deadline for the receipt of completed applications for the 1950 Rural Medical Scholarship was set by the Committee, and copy and layout for a printed folder describing the scholarship were approved.

JOINT MEETING

The Committee selected Wednesday, May 24, as the date for a joint meeting of the Committee and members of the Advisory Committee for the Rural Medical Scholarship. The session to be held in Columbus, will begin at 4 p. m., and conclude with a dinner.

Those present at the April 2 meeting were Dr. Carl A. Lincke, President of the State Association, Dr. E. O. Swartz, President - Elect; Dr. Carll S. Mundy, Chairman of the Rural Health Committee, and Committeemen Jonathan Forman, E. G. Caskey, H. T. Pease, L. E. Anderson, H. R. Mayberry, J. Martin Byers, F. M. Hartsook, Carl Goll, and Kenneth Taylor. Representing the Education Committee were Dr. Carl Wilzbach, Chairman, and members, J. L. Webb and Thomas E. Rardin. Also present were Secretaries Nelson, Saville, Page, and Moore.

Commission Studies Indoctrination In Aspects of Atomic Warfare

A commission of Ohio doctors has been named by Governor Frank J. Lausche to study plans whereby the medical profession and allied groups may be indoctrinated in the aspects of atomic warfare and is scheduled to report its recommendations back to the Governor at a conference arranged in Columbus for May 3.

Nominees, appointed at the request of the National Security Resources Board, are: Dr. Edgar P. McNamee, Cleveland, representing the Ohio State Medical Association; Dr. William G. Myers, Ohio State University College of Medicine, Columbus; Dr. Frank R. Dutra, University of Cincinnati College of Medicine; Dr. Hymer L. Friedell, Western Reserve University School of Medicine, Cleveland; Dr. S. R. Gerber, coroner of Cuyahoga County and secretary of the Ohio Coroners Association; Dr. Harold J. Knapp, Cleveland health commissioner; and Dr. Thomas F. Mancuso, chief of the Division of Industrial Hygiene, Ohio Department of Health, Columbus.

The appointed doctors engaged in an extensive short course the week of April 3 at Western Reserve, one of seven centers designated for similar courses. The National Security Resources Board named Dr. Friedell, who is head of the Radiology Department at the Medical School, to direct the course. Instruction included biological effects of radiation, thermal-burns, methods of detecting radiation, how to treat casualties, handling the injured, and instruction in the types of casualties that would be expected to occur in case of atomic warfare.

Appointed physicians from Indiana, Kentucky, Michigan, West Virginia as well as Ohio were included at the Western Reserve Course.

The commission of doctors is scheduled to recommend plans for a program whereby the physicians of the State will receive training in the aspects of atomic warfare. The plan would entail indoctrinating the entire medical profession and allied professional groups in the treatment of injuries as the result of an atomic attack upon the civilian population.

Welfare Convention

The Central States Regional Meeting of the American Public Welfare Association will be held in Columbus at the Neil House, June 12-13. It will bring together public welfare administrators and workers from Iowa, Minnesota, Missouri, Wisconsin, Illinois, Michigan, Indiana and Ohio.

U. S. Ranks With Leading Nations in Preventing Infant Deaths

Rapid strides in improving and applying medical techniques of caring for babies have made the United States practically equal to any other nation in the world in preventing infant deaths, an American Medical Association study shows.

The study, which was recently completed by Frank G. Dickinson, Ph. D., and Everett L. Welker, Ph. D., Chicago, of the A. M. A. Bureau of Medical Economic Research, and published as Bulletin 73, is summarized in the April 1 *Journal of the A. M. A.*

One reason for the marked improvement in this country's infant death rate is that in recent years the two diseases which are the major causes of deaths of babies over one month and under one year—pneumonia and infant diarrhea—have largely been conquered in most sections of the United States, according to Dr. Dickinson.

This medical advance has brought about a reduction in deaths of babies from six months to a year of age, he said. During 1946, the latest year for which specific information is available, the United States had the world's lowest infant death rate for this age group.

ARE YOU REGISTERED TO VOTE?
IF NOT, ACT PROMPTLY

Drs. Vosburgh and Patek Named At Western Reserve

Two appointments of physicians to fill key positions at Western Reserve University School of Medicine have been announced.

Dr. Gilbert Jay Vosburgh, assistant professor of obstetrics at Johns Hopkins University, has been appointed head of the Department of Obstetrics and Gynecology of the School of Medicine and director of obstetrics and gynecology at University Hospitals.

Dr. Vosburgh will go to Cleveland in July, where he will be the first incumbent of the Arthur H. Bill Chair, recently established. Dr. Bill retired from the University and Hospitals positions in 1948 and is devoting his time to private practice.

Dr. Arthur J. Patek, clinical assistant professor of medicine at Columbia University, has been appointed professor of medicine and director of medicine at Mount Sinai Hospital. He was scheduled to resume his new duties May 1. Dr. Patek is not new to Cleveland. After receiving his degree from Harvard University, he served an internship in medicine at University Hospitals.

Establishment of the position of director of medicine on a full-time basis at Mount Sinai Hospital is in line with affiliation of the hospital with the School of Medicine, and of placing major emphasis on the teaching of medical students and house officers.

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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

HAMILTON

Dr. Carl J. Wiggers, Western Reserve University School of Medicine, Cleveland, delivered the Roger Morris Memorial Lecture for 1950 before the Cincinnati Academy of Medicine on March 7. His talk was a discussion of diseases of the heart.

At the March 21 meeting, Dr. Fred Wharton Rankin, University of Louisville School of Medicine, spoke on the subject, "Lesions of the Lower Gastrointestinal Tract."

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CLARK

Dr. C. W. Hullinger of Springfield spoke before the March 20 meeting of the Clark County Medical Society on the subject, "Postural Backache." The dinner meeting was held at the Ker-Deen Inn.

DARKE

"Mass X-Ray Surveys and Clinical Tuberculosis" was the topic of a talk by Dr. Lynn E. Baker of Dayton before the March 21 meeting of the Darke County Medical Society in Greenville.

MIAMI

In keeping with the theme of April as "Cancer Control Month," the Miami County Medical Society arranged a program on the subject for the April 7 meeting. The topic for discussion was "Carcinoma of the Ovary, Uterine Fundus and Uterine Cervix," with a team from the University of Cincinnati College of Medicine as members of the panel of discussants. They are Dr. Edward Gall, who discussed pathological phases; Dr. Charles M. Barrett, who spoke from the standpoint of the radiologist, and Dr. Lester J. Bosse, who talked on the surgical aspects. The program was arranged in cooperation with the Cancer Committee of the Ohio State Medical Association.

The secretary announced that 130 copies of the book, *The Road Ahead,* had been distributed through members. It was announced also that a new series of radio programs had been arranged over Station WPTW at 10:30 a. m. on Saturdays, entitled "Doctors Make History." It was announced that Dr. E. L. Sutton had opened practice at Tipp City.

MONTGOMERY

Dr. C. O. McCormick, Indiana University School of Medicine, was guest speaker at the March 4 meeting of the Montgomery County Medical Society in Dayton. His talk centered around recommended methods of teaching sex and physiology and pathology of birth in schools.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

PUTNAM

Putnam County Medical Society held its monthly meeting on March 7 at Columbus Grove. Dr. Daniel R. Barr, Grand Rapids, Ohio, was guest speaker and gave an informative talk on "Problems of General Practice." Dr. Barr is secretary for the Fourth District, Ohio Academy of General Practice.

The speaker placed particular emphasis upon high standards of qualification for non-specialist members of hospital staffs. He decried what he termed the overworked and sometimes patronizing term "family doctor" and suggested the term "personal physician" as being more definite and applicable.

Dr. Barr mentioned pre-clinical medicine as being a rich and inexhaustible field for the man practicing general medicine. This, he said, means real, scientific medicine and not social welfare. By the use of his knowledge of the patient's early life, he said, the personal physician often is the logical one to make diagnosis and advise treatment.

WOOD

Dr. Bert Seligman, Toledo, addressed the Wood County Medical Society at its regular dinner meeting at the Midway Restaurant, Perrysburg, March 16. Dr. Ray Whitehead of Bowling Green presided.

Dr. Seligman spoke on the "Differential Diagnosis of Chronic Lymphedema and Venous Insufficiency." Dr. Seligman has had a large experience in this field and his authoritative statements were very much appreciated by the members. Effective treatment in these sectors depends in a great measure on the recognition of the condition.

A rising vote of thanks was tendered Dr. Seligman.

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

ASHTABULA

The Ashtabula County Medical Society observed its annual dinner dance in the Hotel Ashtabula on Feb. 25. Doctors and their wives took part in the festive occasion.

CUYAHOGA

Balloting on a slate of 16 nominees for the Board of Directors of the Cleveland Academy

of Medicine for the three-year term beginning in May is scheduled to be completed by May 12. From the slate, eight members will be chosen. The nominating committee which submitted the names at the March 17 meeting consists of the following members: Dr. O. B. Pomeroy, chairman, Drs. Milton E. Bobey, John F. Boettner, Walter L. George, Clarence P. Huston, Edward F. Kieger and Victor E. Woldman.

The program for April included the following features and speakers:

Internal Medicine Section, April 2—"A Symposium on the Present Status of Antibiotic Therapy"; Moderator, Dr. John H. Dingle; discussants, Drs. R. F. Parker, F. M. Barry and C. H. Rammelkamp, Jr.

Experimental Medicine Section of the Academy of Medicine and Cleveland Section of the Society for Experimental Biology and Medicine, April 14—(1) "The Role of Adrenal Cortex in Alanine Metabolism," Drs. Beecher W. Sitterson, Max Miller, and Jack Owens, and Hiram Woodward, Jr., B. S.; (2) "The Adrenal Cortical Response to Foreign Therapy in Man," Drs. A. M. Potts and L. V. Johnson; (3) "On the Mechanism of Action on Aminopterin," Charles A. Nichol, Ph. D.

Obstetrical and Gynecological Section, April 18—"The Treatment of Toxemia in Pregnancy," Dr. Richard T. F. Schmidt (Co-author, Dr. E. E. Rhoads).

Industrial Medicine and Orthopedic Section, April 19—(1) "Industrial Medicine Today," Dr. E. A. Irvin, Cadillac Motor Car Division, Detroit, Mich.; (2) "Surgical Treatment of Herniated Disc," Dr. Karl S. Alfred.

Dr. John H. Budd has been elected to fill the unexpired term of Dr. Stanley Gardner on the Board of Directors, who resigned upon moving to Florida. The term expires in May, 1952.

GEAUGA

Dr. Fred S. Basquin of Chardon and Dr. Isa Teed Crampton of Burton were honored for their 50 years of medical service in Geauga County at a community banquet at the Chardon Methodist Church on March 9. The affair was sponsored jointly by the Geauga County Medical Society, the Geauga County Kiwanis Club and the Geauga Women's Hospital Association.

The address of the evening was given by Dr. Lucy Stone Hertzog of Chardon. Dr. Hertzog, in praising the records of the two honored doctors, related experiences from the lives of the pioneer doctors who made medical history in Geauga County. She described the local Society as a close-knit organization of well-informed physicians, all of whom are general practitioners.

Dr. Fred W. Dixon, Cleveland, Councilor of the Fifth District of the Ohio State Medical Association, presented the 50-Year Pin and Certificate of the Association to Dr. Basquin and Dr. Crampton.

Dr. Dixon reviewed the history of medicine in the area, pointing out that the first doctor came to Geauga County in 1800. During the last 50 years, he asserted, medicine has advanced more than it did during the previous 5,000 years.

Sixth District

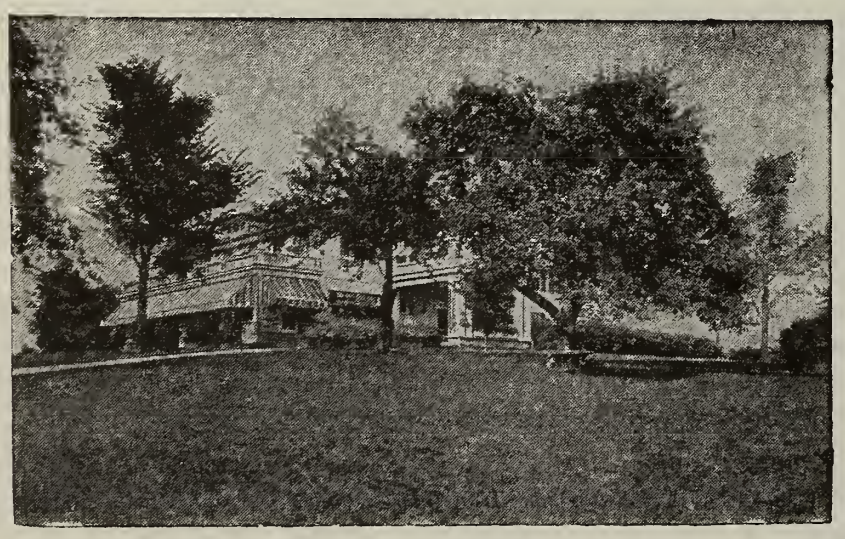
(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

MAHONING

Eleven physicians were honored by the Mahoning County Medical Society at the organization's 78th annual banquet on March 16, when they were presented the 50-Year Pin and Certificate of the Ohio State Medical Association.

Those honored are: Dr. Coyt H. Beight, Dr. C. R. Clark, Dr. C. D. Hauser, Dr. M. E. Hayes, Dr. W. W. Ryall, Dr. D. R. Williams, Dr. H. E. Blott, Dr. W. D. Coy, Dr. A. V. Hinman, Dr. R. E. Whelan and Dr. H. M. Osborne. Drs. Blott, Coy, Hinman, Whelan and Osborne were unable to be present.

Dr. Paul A. Davis, Akron, Councilor of the Sixth District of the Ohio State Medical Asso-



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ciation, made the presentations. Dr. Gordon G. Nelson, president of the Society, presided.

SUMMIT

Dr. Walter C. Alvarez, Rochester, Minn., spoke before the Summit County Medical Society in Akron on March 7. Dr. Alvarez centered his talk around the importance of taking a complete history before making a diagnosis. The talk before the Medical Society as well as a reporter's interview with Dr. Alvarez was given a prominent play in the *Akron Beacon-Journal.*

Guest speaker at an open meeting of the Summit County Medical Society and Auxiliary on April 4 was Dr. Andrew C. Ivy, head of the Department of Clinical Sciences at the University of Illinois College of Medicine, Chicago. Dr. Ivy discussed the subject, "Problems of Overweight." An eight-column feature in the *Akron Beacon-Journal* was devoted to a report of Dr. Ivy's talk.

TRUMBULL

Four members of the Trumbull County Medical Society, Dr. Aubrey L. Sparks, Dr. Louis Razinsky, Dr. Densmore Thomas and Dr. David L. Beers, discussed the subject of government health programs before a meeting of the Warren Business and Professional Women's Club at Trumbull Memorial Hospital.

Dr. Sparks served as moderator and pointed out the advantages and disadvantages of various types of hospitalization, costs of surgical insurance and types of bills presented to Congress.

Dr. Razinsky described the British health plan, and spoke of health plans as practiced in Austria, Germany and France.

Dr. Thomas gave a resumé of American medical advancement under private enterprise and initiative.

Dr. Beers gave statistics on the effect of compulsory insurance based on reports prepared for Congress. A prominent part of the program consisted of questions and answers.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

Five physicians were honored by the Belmont County Medical Society by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. They are: Dr. E. W. Turner, Belmont; Dr. R. H. Wilson, Martins Ferry; Dr. Henry F. Zink, Bellaire; Dr. D. O. Sheppard, Barnesville; and Dr. Homer S. West, St. Clairsville.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M. D., LANCASTER)

GUERNSEY

The Guernsey County Medical Society met in regular session on March 16 at the Berwick Hotel in Cambridge with 10 members present. Dr. Reo M. Swan, president, presided.

Dr. Swan and Dr. Robert A. Ringer reported on the meeting in Columbus of County Medical Society Presidents, Secretaries and Committeemen. They outlined briefly discussions of speakers at the conference.

The scientific program was in charge of Dr. O. R. Martin who chose as his subject, "Why Mental Illness?" The speaker stressed that the newborn infant begins at birth to form its psychiatric pattern and that even these early experiences may have a lasting effect as regards mental health. Dr. Martin furnished each member present with a Public Affairs Pamphlet on "Mental Health Is a Family Affair."

The president announced that members of the Society were invited to attend a meeting of local dentists to hear a discussion on "Oral Cancer."

Dr. F. Gordon Lawyer, secretary, discussed items of current interest contained in the Secretary's Letter from the A. M. A., such as urging physicians and members of their families to register and vote, excessive fees by some physicians, collection of membership dues, etc.

The scientific program at the April 6 meeting of the Society was in charge of Dr. O. R. Jones, who presented the speaker of the day, Dr. Myron A. Freilich of Zanesville. Dr. Freilich spoke on "Digitalis," supplementing his talk with a blackboard resumé of the variations and

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brands, data regarding origin, trade names and dosage. The talk brought out many questions and comments from members.

As a sequel to a letter sent to Mr. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, Columbus, regarding dissatisfaction with the method of handling payments for medical services rendered in Aid for the Aged recipient cases, Mr. John Small from the Columbus office of the Division of Aid for the Aged, appeared and spoke at length regarding the Aid for the Aged program. He was accompanied by the head of the local county office, Mr. Walter Howell. Mr. Small stressed the following points:

1. That aid for the aged program is not a true pension, but rather is a public assistance program under jurisdiction of the Department of Public Welfare.

2. That receipt of aid under the program is based upon need.

3. That need is established when it is shown that the applicant's resources are not equal to basic requirements, such as adequate medical care, food, clothing and shelter.

4. That Ohio law establishes the maximum amount of aid permitted, namely, $55 per month to be allowed.

5. That if further need is established, the law permits an extra $5 per month to be allowed to cover medical expenses; if the recipient is already receiving the $55 maximum allowance, an extra fund of $200 per year is available for extraordinary health requirements.

6. That if this $200 fund proves inadequate in any calendar year, the unpaid difference in excess of the $200 must be sought elsewhere, such as from local relief agencies.

This condition brought out the observation by some of the members that they have been unable to secure cooperation in these cases from the local relief director, although the Society committee had recently signed a new agreement with the county commissioners in which the commissioners agreed to take care of medical fee bills in relief cases. Mr. Howell assured members that he would make every effort to cooperate with the Society in Aid for the Aged cases.

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Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D.,
PORTSMOUTH)

LAWRENCE

A suggestion by a member that a county forum dealing with health problems be started highlighted the March 29 meeting of the Lawrence

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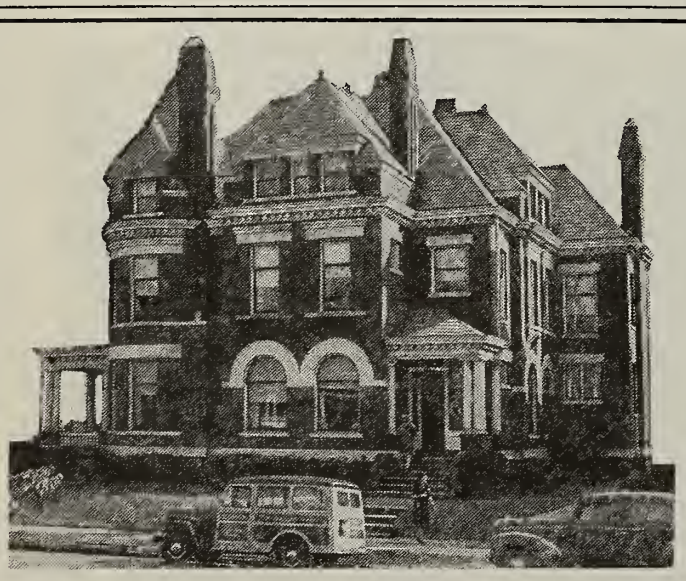
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County Medical Society at which representatives of local labor organizations were present.

Dr. W. W. Lynd suggested "that a County Forum be instituted, and that the Granges of all County Groups take up the idea, so that representatives of labor, industry, the professions, farmers, and all other groups, be instructed in problems of health and medical care in our county and country. This new Forum would meet possibly once a month, and several of the doctors should be present at each meeting."

The group also discussed the questions of the Lawrence County General Hospital deficit, the hospital budget and means to meet it. It was suggested that a county forum might be the solution to this problem also.

Dr. J. N. Rose, city-county health commissioner, was accepted into the Society.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

FRANKLIN

Dr. Robert M. Salassa, Consultant in the Division of Medicine, Section on Metabolism, at the Mayo Clinic, was guest speaker at the April 17 meeting of the Columbus Academy of Medicine. His subject was "Use of Combined Insulin Mixtures in the Treatment of Diabetes."

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M.D., MANSFIELD)

LORAIN

Dr. A. C. Siddall, Oberlin, spoke before the Lorain County Medical Society on the subject, "Cancer Detection in Rural Private Practice," at the March 7 meeting at the Spring Valley Country Club.

"The Anemias" was the subject discussed by Dr. Robert W. Heinle of Cleveland at the April 11 meeting of the Lorain County Medical Society. The meeting was held at the Pueblo in Lorain beginning with a dinner.

RICHLAND

Topic of the program for the March 16 meeting of the Richland County Medical Society was "Translumbar Aortography." It was presented by Dr. Arthur Evans and Dr. Parke G. Smith, both of Cincinnati. A buffet dinner was served at the Mansfield General Hospital. After the scientific program, a business session was held.

A combined meeting of the Medical Society and the active staff of Mansfield General Hospital was held at the hospital on Feb. 23. Dinner was served followed by a business meeting presided over by Dr. R. D. Campbell, president. The program subject was "Local Review of Sterility in Women From a Clinical and Radiological Viewpoint." The clinical aspects were presented by Dr. L. D. Bonar of Mansfield and the radiological aspects by Dr. R. L. Garber, also of Mansfield.

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INCOMING PRESIDENTS

It has been requested by Mrs. George W. Cooperrider, State President-Elect, that county presidents for the 1950-51 term please bring to the Cleveland Convention a list of their full slate of officers and chairmen (both names and addresses) for the ensuing year, or at least as complete a list as is possible.

There will be a specially designated table close to the registration desk where this information may be deposited. Mrs. Cooperrider points out that such cooperation on the part of each new county president will do much toward facilitating the work of all State officers and chairmen in getting activities and materials started promptly for the new Auxiliary year.

ALLEN

A discussion of local health conditions, their deficiencies and the facilities for improving them featured the Feb. 28 meeting of the Allen County Auxiliary held at the home of Mrs. John A. Glorioso. Mrs. Gwen Horre, physiotherapist at St. Rita's Hospital, was the guest speaker. She spoke on "What About Polio?"

The March meeting of the Auxiliary was a panel discussion on "School Health Program" held at the home of Mrs. Carl Zinsmeister. Guest speakers included: Ralph Turner, executive secretary of the Allen County Tuberculosis Association; Mrs. Alfred Schwerin, consulting psychologist of the Mental Hygiene Association; and Mrs. Waldo May, public health nurse.

ASHTABULA

The Student Nurse Recruiting Fund sponsored by the Woman's Auxiliary to the Ashtabula County Medical Society benefited from the style show held by that organization on March 14. One hundred attended the event which was held at the Nurses' Home. Preceding the fashion show, a Conneaut octet was heard in three numbers under the direction of Mrs. R. C. Irving and accompanied by Mrs. Deweese Davis. The octet presented another three selections at the close of the show.

Mrs. Frank Veroni and Mrs. Paul Longaker presided at the refreshment table. Mrs. Donald Forward, fashion show chairman, introduced Mrs. Viola Bilka, the style representative. Others serving on Mrs. Forward's committee included: Mrs. E. N. Wright as co-chairman; Mrs. A. A. DeCato, Mrs. James Macaulay, Mrs. J. R. Higerd and Mrs. C. C. Campbell.

AUGLAIZE

The Auglaize County Auxiliary met on March 15 at the home of Mrs. R. H. Schaefers. A group of local high school students presented an interesting discussion on socialized medicine. The April meeting will be held at the home of Mrs. E. F. Heffner.

CUYAHOGA

The winter meeting of the Woman's Auxiliary to the Cleveland Academy of Medicine was held on Feb. 28 in the Allerton Hotel. Following luncheon, Dr. Shepherd L. Witman, executive director of the Council on World Affairs, discussed "What's New in Democracy." Hostesses for the occasion were Mrs. S. N. Adams, Mrs. John Davis, Mrs. Stanley DeVille, Mrs. R. C. Ernest, Mrs. E. O. Harper, Mrs. E. J. Humel, Mrs. E. W. Parsons, Mrs. Garry G. Bassett and Mrs. Herbert Wright.

Two lecture programs conducted by four doctors' wives were arranged by the Auxiliary for March 21 and March 28, to "brief" auxiliary members on socialized medicine. At the first meeting held at the Medical Library Auditorium, Mrs. N. L. Farnacy, graduate of the Cleveland School of Law, spoke on "What Does the Government Plan for Medicine?" Mrs. C. S. Higley discussed "Is A Compulsory Program Neces-

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sary?" Mrs. Higley is a former medical social worker, active in many civic projects.

The second meeting, on March 28, presented Mrs. U. V. Portmann and Mrs. Farrell Gallagher as the speakers. Mrs. Portmann's topic was "What Do the Doctors Propose?" She is vice-president of the Council on World Affairs and active in community projects. Mrs. Gallagher spoke on "What Can We Do?" She is state auxiliary public relations chairman and legislative chairman of the Diocesan Council, National Council of Church Women.

The Cuyahoga County Auxiliary also had the distinction of editing the February issue of the bulletin of its Academy of Medicine.

DELAWARE

Health legislation was the topic of discussion at the luncheon meeting held on March 21 by the Woman's Auxiliary to the Delaware County Medical Society at Bun's Restaurant. Mrs. Wray Davis presented a report of the conference of officials of county medical auxiliaries held on March 14 in Columbus that was sponsored by the Ohio State Medical Association.

Mrs. George T. Blydenburgh read a report of a British physician who practiced socialized medicine in England during 1948 and 1949. The discussion was concluded with a question-and-answer period, led by Mrs. Edward C. Jenkins, concerning the problems and weaknesses of socialized medicine.

The Auxiliary voted to give to each of the 12 Delaware city and county high schools a subscription to *Today's Health.*

ERIE

Mrs. E. J. Meckstroth will serve as the 1950-51 president of the Woman's Auxiliary to the Erie County Medical Society. The election of officers followed the Auxiliary's March luncheon at the Business Women's Club at which the guest speaker, Dr. W. P. Skirball, discussed neuropsychosis.

Serving with Mrs. Meckstroth will be Mrs. H. W. Lehrer as president-elect; Mrs. Paul N. Squire as vice-president; Mrs. C. J. Reichenbach as secretary; and Mrs. A. G. Groscost as treasurer. The luncheon tables were appointed in a St. Patrick's Day motif with shamrocks as place favors. Hostesses were Mrs. Reichenbach, Mrs. A. R. Warner and Mrs. Watson Parker.

Highlights of the Columbus conference held for county auxiliary presidents by the Ohio State Medical Association were presented by Mrs. Lehrer, Mrs. Carl E. Swanbeck, Mrs. Meckstroth and Mrs. Ross Knoble. It was announced that the Auxiliary was making plans for a "doctors' party" scheduled for April 29 at the Plum Brook Country Club.

FAIRFIELD

The Auxiliary to the Fairfield County Medical Society met on March 10. Following a dessert-

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GYNECOLOGY—Intensive Course, Two Weeks, starting June 19, September 25. Vaginal Approach to Pelvic Surgery, One Week, starting May 15.
OBSTETRICS—Intensive Course, Two Weeks, starting June 5, September 11.
PEDIATRICS—Personal Course in Cerebral Palsy Two Weeks, starting July 31. Personal Course in Diagnosis & Treatment of Congenital Malformations of the Heart, Two Weeks, starting June 5.
MEDICINE—Intensive General Course, Two Weeks, starting October 2. Electrocardiography & Heart Disease, Two Weeks, starting July 17. Hematology One Week, starting May 8. Gastro-enterology, Two Weeks, starting May 15. Liver & Biliary Diseases, One Week, starting June 5. Gastroscopy, Two Weeks, starting May 15, June 12.
DERMATOLOGY—Formal Course, Two Weeks, starting May 8. Informal Clinical Course every 2 weeks.
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luncheon, Mrs. F. W. James presided over the business session. Reports of standing committees were presented and projects discussed. Mrs. James and Mrs. C. P. Swett told about the Columbus conference for county auxiliary officials. Hostesses for the March meeting were Mrs. L. E. Stenger, Mrs. V. A. Simiele and Mrs. F. E. Spangler.

JEFFERSON

A donation to the Nurses' Scholarship Fund was voted at the March 27 meeting of the Jefferson County Auxiliary, held at the home of Mrs. Edward Weinman. A nominating committee for the election of new officers was appointed and includes: Mrs. Stanley Burkhart, chairman; Mrs. Samuel Greenburg and Mrs. L. J. Kerschgens. The afternoon's program featured a talk by Mrs. H. E. Thompson on floral arrangements. Refreshments were served later by the hostess, with Mrs. Albert Sunseri assisting.

KNOX

The Woman's Auxiliary to the Knox County Medical Society met on March 30 at the home of Mrs. Richard Gomer. The business meeting was conducted by Mrs. J. L. Baube who reported on the Columbus conference held on March 14. Mrs. Henry Lapp, Mrs. George Imhoff and Mrs. R. L. Eastman were named to the nominating committee. Mrs. John Drake, Mrs. Charles Tramont and Mrs. Julius Shamansky were appointed to the ways and means committee.

Mrs. C. E. Cassaday, program chairman, introduced Mr. L. S. Allen, local jeweler, who spoke on the "Romance of Gems" and exhibited a valuable collection. An arrangement of pink roses centered the refreshment table at which Mrs. James F. Lee presided. Joint hostesses were Mrs. Raymond Lord and Mrs. Robert Hoecker.

LICKING

Mrs. Roland Jones was elected president of the Woman's Auxiliary to the Licking County Medical Society at its dinner meeting on March 28 at the Moundbuilders Country Club. The tables were prophetic of Spring with their center arrangements of forsythia, pussy willows and tall yellow tapers.

Chosen by the Auxiliary to serve with Mrs. Jones are: Mrs. Donald Sperry, president-elect; and Mrs. Paul Grove, vice-president. Mrs. Ralph Pickett was reelected secretary and Mrs. Wendell Steele, treasurer. The Auxiliary voted again to sponsor a high school girl interested in a nursing career. The scholarship will be given outright to the student who rates in the upper third bracket of her class at graduation. She will be given the opportunity to choose the hospital in which she wishes to take her training.

Mrs. Jones and Mrs. J. Y. Salzman reported on the Columbus conference held at the Fort

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Hayes Hotel on March 14. Plans for a rummage sale were also discussed.

LOGAN

Mrs. John B. Traul was hostess when the Auxiliary to the Logan County Medical Society met on March 28 for its regular monthly meeting. Mrs. Warren Mills presided in the absence of the president. The topic "Public Relations" was presented by Mrs. Charles Thompson, following which a general discussion was held. A social hour followed the business session when refreshments were served.

OTTAWA

The Ottawa County Auxiliary held its March 9 meeting at the home of Mrs. James Rhiel. Plans were made for a tea and a tour of the hospital in April for junior and senior high school girls in the county who are interested in nursing.

RICHLAND

A luncheon meeting was held on April 3 at the Women's Club by the Auxiliary to the Richland County Medical Society. Mrs. Ralph Wharton and Mrs. Sigmund Smedal were hostesses. Arrangements of yellow roses, daffodils and lavender iris centered the luncheon tables.

Mrs. F. J. Heringhaus, president, conducted the business session. A report on the meeting of the coordinating council was given by Mrs. Smedal. Mrs. Robert Crawford stated that seven members attended the state conference in Columbus. The May meeting which will be the last one until the Fall will be held on May 22. At that time, election of officers will take place and annual reports given.

Plans for the Wood County Hospital, Bowling Green, and the Defiance Hospital, Defiance, are featured for their "generally excellent design" in a special section entitled "A Profile of Hospital Construction" in the April, 1950, issue of *Hospitals*, the journal of the American Hospital Association.

A nationally integrated study of the nation's potential capacity to collect and store whole blood will begin soon at a meeting in Washington of the agencies concerned, both Federal and private. Invited to participate are the American Red Cross, American Association of Blood Banks, National Research Council, Department of Defense, Federal Security Agency, Atomic Energy Commission and the Veterans Administration. The project is in charge of Dr. Norvin C. Keifer, formerly of Geneva, Ohio, and now medical director of the National Security Resources Board.

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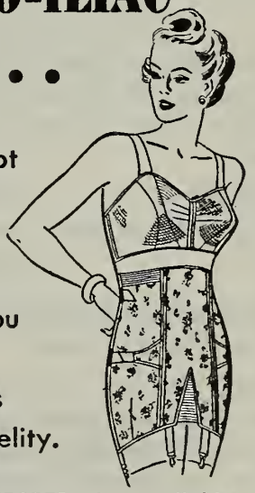
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Payment of A. M. A. Dues Explained In Question-Answer Form

Many questions have been directed to the Headquarters Office in Columbus as well as to the A. M. A. Headquarters regarding payment of the A. M. A. dues voted by the House of Delegates at its December, 1949, meeting.

The following are typical of the many questions being asked and are reproduced herewith together with answers furnished by the Secretary of the A. M. A. This additional information is given for the benefit of Ohio physicians who may wish to review the information contained.

Question: Does the American Medical Association require the payment of dues by its members?

Answer: Yes. For the first time in its history, the members of the American Medical Association in 1950 will pay membership dues. These dues apply to all members of the Association except those in three specific categories.

Question: What is the amount of the dues for 1950?

Answer: $25.

Question: What are the American Medical Association 1950 membership dues of a physician who joins his county medical society after July 1?

Answer: Dues for physicians who become members after July 1, 1950, are $12.50. The dues for all members before July 1 are $25.

Question: Does a member who transfers from one state or county to another pay American Medical Association membership dues a second time?

Answer: No. A member pays his American Medical Association dues only once in a calendar year.

Question: By what authority were the dues set at the $25 level?

Answer: On recommendation of the Board of Trustees and approval by the House of Delegates in December 1949 in accordance with the provisions of the Constitution and By-Laws of the American Medical Association.

Question: What members are exempt from the payment of American Medical Association membership dues for the year 1950?

Answer: (a) Members for whom the payment of dues constitutes a financial hardship as determined by their local medical societies.

(b) Members in actual hospital training for not more than five years after graduation from medical school.

(c) Members who have retired from active practice.

In all instances exemption may be allowed only if the member is also exempt from state and county medical society dues. (Note: This is not possible in Ohio under the present By-Laws.)

Question: To whom should the American Medical membership dues be paid?

Answer: To the local or state society, depending on the system of payment established by the state medical association concerned.

Question: When should American Medical Association 1950 membership dues be paid?

Answer: When the member receives his bill from his local or state society. No remittance

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THE SOCIETY for INVESTIGATIVE DERMATOLOGY
will hold its
ELEVENTH ANNUAL MEETING
at the Clift Hotel, San Francisco, California, on Sunday June 25, 1950
(See Archives of Dermatology and Syphilology, May, 1950, for Scientific Program.)

of membership dues should be made directly to the American Medical Association.

Question: What is the relation between American Medical Association membership dues and Fellowship dues?

Answer: (a) The status of Fellowship and Fellowship dues has not been changed by the establishment of American Medical Association membership dues.

(b) Members may become Fellows—subject to approval by the Judicial Council—by requesting such status on a form supplied by the American Medical Association.

(c) Fellowship dues of $12 and membership dues of $25 are separate dues. Members who are or who become Fellows, therefore, pay a total, combined Fellowship and membership dues, of $37.

Fellowship dues include subscription to *The Journal of the American Medical Association* or to one of the special journals.

Question: What is a Service Fellow?

Answer: Commissioned medical officers of the Armed Forces and the United States Public Health Service and permanent medical officers of the Veterans' Administration may become Service Fellows of the American Medical Association on nomination by their chief medical officers and approval by the Judicial Council. Service Fellows are not required to pay Fellowship dues and do not receive any publication of the Association except by personal subscription.

Question: Must a Service Fellow be also a member of the American Medical Association?

Answer: No. Service Fellowship is a special category of Fellowship established for physicians in full time Government service, many of whom are not eligible for membership in their local medical societies. However, a Service Fellow who is a member of a local medical society may elect to pay American Medical Association dues for 1950 and thereby continue his membership in the American Medical Association.

Question: What action is taken when there is failure to pay American Medical Association membership dues?

Answer: Members who are delinquent in the payment of American Medical Association dues for one year and who fail to pay such delinquent dues within 30 days after receipt of notification from the Secretary of the American Medical Association will forfeit membership in the American Medical Association. Retention of membership in the local and state medical societies under these circumstances will depend on the local action of those societies.

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Survey Indicates Large Percentage Favors Free Medical System

Compulsory health insurance is far from popular among the city folk, according to a survey recently completed by the Psychological Corporation, New York, in 25 cities and towns from coast to coast.

They asked the question:

"Which do you favor: (a) To have government give free doctor and medical service which would be paid for by a three per cent payroll tax on all wages under $3,600, or, (b) the present system of medical service?"

65 per cent favored the present medical system;
26 per cent favored government medicine;
9 per cent were uncertain.

Even in the lower income group, the lowest third which is supposed to benefit most from government medicine, 51 per cent were against the plan while 37 per cent favored it.

In an April, 1947, survey on what people consider good and bad Americanism, the following question was asked:

"Which is better for America: (a) To have the government give free doctor and medical service which would be paid for by a tax like the Social Security tax; or, (b) the present system of medical service?"

63 per cent favored the present medical service;
30 per cent favored government medicine;
7 per cent were uncertain.

Insofar as the two surveys are comparable, it would seem that in spite of government propaganda in favor of socialized medicine, there has been little change in the proportion of people who favor government medicine.

Effects of America's declining birth rate and lengthening life span will be made the subject of a five-year study by the University of California's Institute of Industrial Relations, supported by a Rockefeller Foundation grant of $125,000.

COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Cleveland, May 16-18.

American Medical Association, Annual Session, San Francisco, June 26-30.

American College of Radiology, San Francisco, Calif., June 25.

American Pediatric Society, French Lick, Ind., May 8-10.

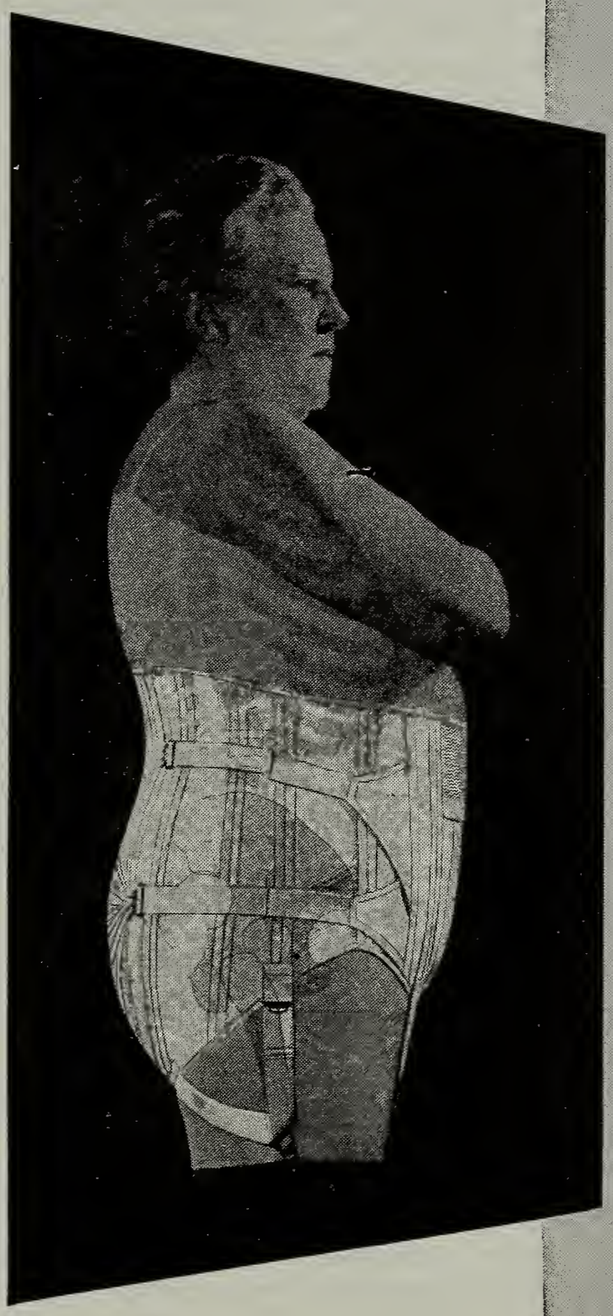
Conference of County Medical Society Officers, San Francisco, June 25.

Eighth Councilor District Annual Meeting, McConnelsville, June 15.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Kate Fuller, M. D., by Dorothy Pierce Walker ($2.50. *Macrae Smith Co., Philadelphia)*, is the story of a beautiful and learned intern, and the obstacles encountered by the modern woman in hospital work where men like women but dislike them in their business. You may remember the author's **Five O'Clock Surgeon.**

Society and Its Criminals, by Paul Reiwald ($4.50. *International Universities Press, Inc., New York City)*, will provide a key for the large number of persons who are concerned with the modern problems of crime. It is a comprehensive exposition of what psychoanalysis has taught us about crime, and society's attitude towards it.

Comroe's Arthritis and Allied Conditions, completely revised and rewritten by Joseph L. Hollander and 16 associates ($16.00. Fourth Edition. *Lea & Febiger, Philadelphia)*, stands as the best in its field and as a fine memorial to Bernard Isaac Comroe, M. D. Eleven hundred pages by the outstanding specialists in America, including Philip S. Hench's discussion of Compound E.

Mitchell's Pediatrics and Pediatric Nursing, by Robert A. Lyon, M. D., and Elgie M. Wallinger, of Columbus Children's Hospital ($3.75. Third Edition. *W. B. Saunders Co., Philadelphia)*, presents an enlarged chapter on growth and development and new emphasis on individual nursery care and the psychological phases of medical treatment.

Eye, Ear, Nose and Throat Manual for Nurses, by Roy H. Parkinson, M. D. ($3.00. Sixth Edition. *C. V. Mosby Co., St. Louis, Missouri)*, is divided into three parts: One for the undergraduate, one for those in the operating room, and one for the public health nurse in the field. No field has been more profoundly influenced by the advent of "the Miracle Drugs" than this one.

Methods of Teaching in Schools of Nursing, by Alice B. Brethorst, R. N., Ph. D. ($4.00. *W. B. Saunders Co., Philadelphia)*, gives us some 300 pages on pedagogical practices that the author has found important in her 20 years of teaching nursing.

Obstetric Management and Nursing, by Henry L. Woodward, M. D., and Bernice Gardner, R. N., ($4.00. Fourth Edition. *F. A. Davis Co., Philadelphia)*, is a revised edition of this standard text for nurses from Christ Hospital, Cincinnati, Ohio. All new developments in the past five years in the care of the normal mother and her child are adequately covered.

Quinidine in Disorders of the Heart, by Harry Gold, M. D. ($2.00. *Paul B. Hoeber, Inc., New York City)*, is a concise manual on how to obtain the maximum therapeutic results from the use of this drug in disorders of cardiac rhythm. Particular stress is placed on the rationale of every procedure recommended.

Vitaminology, by Walter H. Eddy, Ph. D. ($6.00. *Williams & Wilkins Co., Baltimore, Maryland)*, gives the complete story to date of the chemistry and functions of the vitamins. Each vitamin is discussed authoritatively as to what it does, its place in the chemical field, and its value in human and domestic animal nutrition.

How To Stay Healthy, by Irving S. Koll, M. D. ($2.75. *Ziff-Davis Publishing Co., Chicago)*—a popular little book of 200 pages which makes good use of words to tell the story of positive health by a practicing physician. It is a book to give your health-conscious patient or to study yourself if you do radio talks or popular lecturing.

Doctor Will, by Pauline Stiles ($3.00. *Bobbs-Merrill Co., Indianapolis)*, a tale of the West at the turn of the century. Another good story about a humane physician of the days that are gone.

Your Nasal Sinuses and Their Disorders, by Albert P. Seltzer, M. D. ($2.50. *Froben Press, New York City)*, is a well-illustrated popular exposition. The author, in your reviewer's opinion, evaluates injection, physical agents, allergy, and emotional disorders as the causes of "sinus."

An Atlas of Traumatic Surgery with Illustrated Histories of Wounds of the Extremities, by Josep Trueta, M. D. ($7.50. *C. C. Thomas, Publisher, Springfield, Illinois)*, is based upon the author's war experience at the Wingfield-Morris Orthopaedic Hospital, Oxford, England. The photographs were chosen from thousands because they do illustrate a point in management.

Electrocardiography, Fundamentals and Clinical Application, by Louis Wolff, M. D., ($4.50. *W. B. Saunders Co., Philadelphia)*, teaches the basic principles without referring to the clinical patterns. The author's experiences in teaching this subject convince him of the necessity of using this new approach. It is, however, strictly a practical book.

Diseases of the Nervous System, by F. M. R. Walshe, M. D. ($5.00. Sixth Edition. *Williams & Wilkins Co., Baltimore, Maryland)*, presents

an entirely rewritten text on neurosyphilis with special reference to treatment. The sections on acute poliomyelitis and intracranial abscess have been enlarged and reëmphasized. The fact that the previous edition was translated into both French and Spanish speaks for this book.

Questions, Medical State Board, and Answers, by R. Max Goepp, M. D., and Harrison F. Flippin, M. D. ($7.00. Eighth Edition. *W. B. Saunders Co., Philadelphia),* is the first edition of this standard text which can be called "the old dependable" for all who have crammed for exams these 40 years to my personal knowledge.

Aviation Medicine, by Kenneth G. Bergin, M. D. ($7.00. *Williams & Wilkins Co., Baltimore, Maryland),* is a comprehensive but concise manual dealing with all phases of the subject. It has been written by the physician to the British Overseas Airways Corporation with the help of many on both sides of the ocean.

A Manual of the Penicillia, by Kenneth B. Raper and Charles Thom ($12.00. *Williams & Wilkins Co., Baltimore, Maryland),* is a manual prepared under the joint sponsorship and support of the National Science Fund and members of the staff of the Department of Agriculture. It is a must for the library of everyone interested in the green molds.

Bedside Diagnosis, by Charles Mackay Seward, M. D. ($3.50. *Williams & Wilkins Co., Baltimore, Maryland),* is a delightful book by a distinguished British physician. In these days of laboratory tests and gadgets, we can all profit by reading it.

A Manual of Physical Therapy, by Richard Kovacs, M. D. ($3.75. Fourth Edition. *Lea & Febiger, Philadelphia),* has been reprinted each year for the last five years and now it comes to us revised and brought up to date as a concise manual of the entire subject.

Surgical Management of Vascular Diseases, by Gerald H. Pratt, M. D. ($10.00. *Lea & Febiger, Philadelphia),* represents the way this field of surgery has developed into an important and rapidly expanding surgical specialty. The author has specialized in this field for the past twelve years. His research and publications are familiar to all. This wide experience, as his old chief, W. Wayne Babcock, observes in his introduction, has particularly fitted him to write this timely book.

Resuscitation and Anesthesia for Wounded Men, by Henry K. Beecher, M. D. ($5.50. *C. C. Thomas, Publisher, Springfield, Illinois),* presents the lessons of the last decade in the management of traumatic shocks. It deals especially with the patient's care during the critical period from the time he is hurt until the surgeon repairs his wounds.

Bridges' Dietetics for the Clinician, by Harry J. Johnson, M. D. ($12.00. Fifth Edition. *Lea & Febiger, Philadelphia),* has been brought up to date by an associate of the author. It incorporates the practical advances in the field of nutrition—what each of us needs to know.

Internal Medicine in Dental Practice, by Bernard I. Comroe, M. D., Leon H. Collins, Jr., M. D., and Martin P. Crane, M. D., ($6.50. Third Edition. *Lea & Febiger, Philadelphia),* presents a "speaking knowledge" of modern internal medicine for the dentist.

Diseases of the Foot, by Emil D. W. Hauser, M. D. ($7.00. Second Edition. *W. B. Saunders Co., Philadelphia),* was written to fill a need among physicians by a famous orthopedic surgeon. Most of us know all too little about the foot and its diseases. Four hundred pages of most useful information.

The Medical Annual, 1949 ($7.00. *Williams & Wilkins Co., Baltimore, Maryland),* is a yearbook of treatment and a practitioner's index written by a group of distinguished British physicians.

Medicine Could Be Verse, by Charles G. Farnum, M. D. ($3.00. *Exposition Press, New York City),* is light verse—most humorous—mostly about physicians—by a distinguished industrial surgeon. Delightful—a nice gift for your physician friend.

Group Medicine and Health Insurance in Action, by Robert E. Rothenberg, M. D., Karl Pickard, M. D., and J. E. Rothenberg, Introduction by George Baehr, M. D. ($5.00. *Crown Publishers, New York City),* is the detailed story of the Central Medical Group of Brooklyn—its origin, its plan, its operation, utilization and business side, the legal aspects of its practices, personnel problems, standards, and physical requirements. All who are interested in cooperatives, insurance, or group practice will want to read these 300 pages—study them in fact.

Practical and Theoretical Aspects of Psychoanalysis, by Lawrence S. Kubie, M. D., ($4.00. *International Universities Press, Inc., New York City);* is a revision of the book of 1936. The old chapters have been largely rewritten and expanded while new chapters on therapy and on social and cultural implications of the method have been added. It is the answer from the practitioner's point of view as to whether psychoanalysis can help in particular cases.

Manometric Techniques and Tissue Metabolism, by W. W. Umbreit, R. H. Burris and J. F. Stauffer. ($4.00. *Burgess Publishing Co., Minneapolis, Minnesota),* is designed to be a practical laboratory manual to place in the hands of the beginner, produced by the staff at the University of Wisconsin.



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The Ohio State Medical Journal

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Vol. 46 June, 1950 No. 6

JONATHAN FORMAN, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

The Etiology and Rationale of Treatment of Common Bile Duct Pathology

H. VERN SHARP, M. D.

COMMON bile duct pathology manifests itself in varying degrees of obstruction, pressure changes within the ductal system, infection, and tumor.

The lesions of the common bile duct which cause the obstructive symptoms in the order of their frequency of occurrence are: Stones, empyema or acute cholecystitis, stricture, enlargement of the head of the pancreas, and tumors within the duct.

The effects of obstruction to the common bile duct depend upon two factors; a. duration of the obstruction, b. the presence or absence of infection. The biliary obstruction is usually intermittent in type allowing for periods of relief where the liver and ducts recover somewhat from the effects of the biliary stasis. The stasis here is analogous to that of the urinary tract, and in the absence of infection, causes a hydro-hepatosis with progressive dilatation of the duct system and a corresponding atrophy of the parenchyma. Complete blockage of a duct by stone, stricture or accidental tie have been reported with the entire lobe drained by that duct undergoing atrophy. Infection, however, is the rule, with a progressive cholangitis extending throughout the extra and intra-hepatic biliary system, with resulting fibrosis, destruction of the hepatic cells and proliferation of the ducts, typical of obstructive biliary cirrhosis.

Stone in the common duct is the most common cause of obstruction and is associated with an infection in the walls of the gallbladder and the bile duct system. It causes hepatic and pancreatic lesions of all grades of severity. Stones may be present for years without causing objective symptoms until irritation of the mucous lining of the duct causes inflammatory reaction with edema about the stone and variable occlusion of the duct. Judd and Marshall[1] in 1931 called attention to startling figures when they published an analysis of 1,608 cases from whom stones were removed from the common bile duct; 26.5 per cent of these cases gave no history of jaundice. One in ten patients who have stones in their gallbladder also have stones in the common duct. Pancreatitis was present as an associated lesion in 26 per cent of cases and some degree of cholangitis was present in most cases. Varying degrees of hepatic and biliary cirrhosis were seen in the liver especially where the condition was of long standing. Comparable findings are recognized

Presented before the Section on Surgery at the Annual Meeting of the Ohio State Medical Association, Columbus, Ohio, April 19, 1949.

The Author

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by many surgeons who have evaluated their own biliary tract cases.

Lahey[2] is of the opinion that most stones found in the common and hepatic bile ducts have originated there as a result of disturbed metabolism or infection secondary to a diseased gallbladder. This assumption is open to question but the fact remains that stones are present in the extra-hepatic duct system in about 13 per cent of persons having stones in the gallbladder.

Acute cholecystitis and empyema of the gallbladder causes obstruction of the common bile duct by pressure upon the extra-hepatic bile ducts due to enlargement of the gallbladder and pericholecystic inflammatory reaction and edema.

Obstruction due to stricture of the common bile duct is not infrequent. The benign stricture of the duct is due to injury, most frequently following the trauma of a previous operation. It may be due to infection of peri-cholecystic disease, ascending cholangitis, stone or scar of duodenal ulcer. Anomalous positions of the cystic and right hepatic ducts are a cause of injury at operation with resultant stricture. The cystic duct runs parallel to the common hepatic duct in 33 per cent of the cases and occasionally the right hepatic duct empties into the cystic duct. Varying positions of the cystic and right hepatic arteries contribute to their possible tear or slipping from a clamp with a hurried effort to control hemorrhage and resulting accidental injury to the hepatic ducts. The possibilities of all degrees of trauma to the actual tying off or severing of the major bile duct become apparent. In malignant stricture of the common bile duct, the obstruction is usually rapid and the infection is a terminal event. The tendency to metastasize is slow.

Obstruction due to enlargement of the head of the pancreas is usually secondary to inflammatory conditions in the biliary tract although it may be primary in the pancreas or a malignancy in the head of the pancreas. It is evident why even slight enlargement of the head of the pancreas should cause obstructive symptoms of the common bile duct when it is remembered that in two out of three cases the common duct passes through the substance of the head of the pancreas.

A rise in the fluid pressure within the duct system due to dyskinesia is a clinical entity brought about by parasympathetic stimulation or chemical irritation causing a spasm of the smooth muscle fibers of the sphincter of Oddi. All of the symptoms of temporary common duct obstruction may result. A rise in the bile pressure of the common duct to more than 350 mm. of water pressure, which is the secretory pressure of the liver, causes pain. This pain often exactly simulates the type of pain complained of before the removal of the gallbladder and common duct stone.

In a differential diagnosis of common bile duct pathology the history usually offers the most helpful clue. Osler's descriptive triad of intermittent colicy pain, chills and fever, and jaundice are characteristic and any one of the combination should at once arouse curiosity in the biliary duct system. The laboratory is of aid in giving blood bilirubin levels, prothrombin time as a clue to clotting time as well as an estimate of liver damage, a fragility test to differentiate hemolytic icterus, a urobilinogen test of the urine to aid in diagnosing the type of obstruction, and the use of a soft duodenal tube to determine the amount and kind of bile present in the intestinal tract.

RATIONALE OF TREATMENT OF COMMON BILE DUCT PATHOLOGY

The medical treatment of diseases of the biliary passages by diet, duodenal drainage, cholagogues and biliary antiseptics is unsatisfactory at its best and in many instances may do actual harm by postponing the adoption of radical surgical procedures. The medical management includes the effort to balance the physiology by an adequate fluid, electrolyte, carbohydrate and protein intake, vitamin K therapy when indicated, and use of the water soluble vitamin B and C in quantities well in excess of estimated requirements.

One cannot lay too much stress on the early relief of obstruction of the common bile duct. Drainage of the infected biliary system is essential before jaundice becomes profound or the hepatic injury advanced. Removal of the infected gallbladder at the primary operation is the method of choice, but if this procedure is too hazardous, drainage should be done with the thought of removal later when the patient's condition warrants.

Cattell[3] reports exploration of the common duct in 48.8 per cent of 909 patients with the finding of common duct stones in 128 of them, or 14.1 per cent. Waltman Walters[4] reports common duct exploration on 25 per cent of 1,172 patients from whom the gallbladder was removed. Stones were found in 126, or 42.6 per cent of common bile ducts explored. The question may be raised, "Why is it necessary to explore the common duct in approximately one-half of all patients operated upon for gallbladder disease?" The answer being that there is no group of symptoms or physical findings either before or at the time of the operation which can serve justly to exclude the presence of stones in the common duct. The common bile duct should be explored if there is a history of jaundice, if at operation the duct is found to be dilated and yellowish-white in color or even thickened, if

small stones are present in the gallbladder and there is a patent cystic duct, if the palpation of the duct is at all questionable, when acute and subacute pancreatitis is present and if sediment is aspirated from the common duct bile. If the history is fairly typical and a dilated thickened duct demonstrable at the exploration, it may be advisable to explore the ampulla by the transduodenal route before one can be sure no impacted sediment or stone is present in the ampulla.

After opening of the common bile duct, whether for removal of the stone or exploration, a period of drainage should be provided for by insertion of a catheter or preferably a T-tube. Drainage through this tube will relieve the associated cholangitis, hepatitis and pancreatitis. It also provides a medium for direct roentgen study.

By the injection of diodrast into the T-tube and X-ray picture of the duct system, the presence or absence of residual stones is determined and the extent of intrahepatic biliary pathology as demonstrated by greatly dilated inelastic and stunted ducts. Thus the increasing practice of choledochostomy, coupled with a routine postoperative cholangiography, is often revealing. The careful separate observations of Young,[5] Brunning,[6] and W. Mayo[7] found at postmortem examination in patients operated upon for common duct stones that stones were overlooked in from 16 to 25 per cent of the cases. This appalling number of residual stones in the bile duct system following surgery offers a real problem to the surgeon and patient. It is explained by the marked dilatation of the intrahepatic bile ducts where many stones may defy all the present methods of finding them. Cholangiograms at the operating table are too often unsatisfactory to be of routine value. The attempt to force the passage of the stones by means of dilating the spincter of Oddi or to dissolve the stones to allow their passage has met with success in some cases of retained common bile duct stones. Pribram[8] reports successful results in 38 cases where ether was instilled into the tube followed by liquid paraffin. In his experience the cholesterol was dissolved by the ether and the liquid paraffin reduces the stones into a soft pulp. He uses a double lumen catheter which relieves the pressure caused by the ether. Those using his solution, but using T-tubes, have reported unfavorable constitutional reactions. Other workers[9] attempting to find a non-toxic liquid which was readily obtainable and would bring about the chemical reduction of cholesterol and calcium salts used solution G (which closely resembles magnesium citrate U. S. P). Solution G causes bile flocculation but actually does not reduce the bile duct stones chemically. The satisfactory results in the passage of the duct stones while using solution G must be explained in some other manner than the dissolution of the stones.

Harris and Marcus[10] first suggested the use of nupercaine solution to attempt to relax the sphincter of Oddi followed by normal saline irrigation to force the stones into the duodenum. I am familiar with four cases treated by one or a combination of the mentioned solutions. The series is admittedly small but the results are so startling that they are out of all proportion to a number.

CASE REPORTS

Case 1. L. B., female, 34 years of age. History of gallbladder attacks for three years accompanied by a mild jaundice. This attack is of four days' duration with a serum bilirubin of 3.9 mgm. At operation, a thickened gallbladder containing numerous small stones was removed. Many stones, measuring up to 1 cm. in longitudinal diameter, were then removed from the common bile duct and both hepatic ducts. The ductal system was then flushed out with saline and a Bake's dilator of 8 mm. size passed through the sphincter of Oddi and a small T-tube inserted into the common bile duct. Chemical analysis of the stones proved them to consist of cholesterol with a faint trace of bile pigment.

Cholangiogram taken nine days after operation revealed, "marked dilatation of the common duct which contains numerous calculi; possible stones within the liver near the distal portion of hepatic radicles." Daily T-tube instillation was begun of 10 cc. of 1:500 nupercaine solution for 15 minutes followed by 30 cc. of normal saline. During the first instillation the patient complained of pains similar to her gallbladder attacks. The succeeding treatments caused very little discomfort.

At the end of two weeks daily instillations of the nupercaine solution, a cholangiogram reading gave, "loss of all but possibly two of the non-opaque calculi." At this time solution G was started as a constant drip, 15 drops per minute, into the T-tube. Three days later the patient developed a sudden severe pain in the right side of the abdomen and vomited. This was soon relieved and it was thought it indicated the passage of a stone into the duodenum. Cholangiogram done five days later revealed "no evidence of calculus at this time."

This experience would tend to show how easy it is to overlook stones when the bile radicles have become so greatly distended, the value of doing cholangiograms and results of treatment where persistence is necessary.

* * *

Case 2. B. F., female, 31 years of age. History of typical gallbladder attacks for past ten years accompanied by jaundice. At operation a gallbladder containing a number of small stones was removed. Three small stones were removed from the dilated common duct and the duct system thoroughly explored, flushed out, and No. 8 Bake's dilator passed through the sphincter of Oddi. Small T-tube was then placed within the common duct. Nine days after operation and an uncomplicated convalescence, including intermittent clamping of the T-tube without symptoms, a routine cholangiogram was taken with the following interpretation, "Excellent filling of common duct and liver radicles. One notes the presence of a non-opaque square

defect at the ampulla, possibly represents a non-opaque facetted common duct stone causing obstruction."

Treatment was begun using daily instillations of 10 cc. of 1:500 nupercaine solution into the T-tube, clamping the tube 15 minutes and flushing out with normal saline. Two days later the cholangiogram revealed no evidence of obstruction or non-opaque calculus and the T-tube was removed two days later.

* * *

Case 3. B. W., female, 30 years of age. History of attacks of pain for ten years occurring in the upper right quadrant of the abdomen radiating into the back and accompanied by nausea and vomiting. This attack began two weeks ago accompanied by a progressive jaundice. At operation a small thickened gallbladder was removed containing a single round stone and muddy material. The dilated thickened common duct was opened and found to contain white bile, muddy material and the ampulla filled with stones. Nine stones were removed from the distal common duct and the final stone removed with difficulty from the ampulla. The ductal system was flushed out and a medium sized T-tube placed into the common duct.

A cholangiogram taken nine days after the operation, "shows the presence of five rounded calculi lying in the common duct between the inferior tip of the T-tube and the Vater ampulla. No spillover into the duodenum." On this date treatment was begun by injecting 20 cc. of 1:500 nupercaine solution slowly into the T-tube, clamping the tube for 15 minutes then irrigating the same with normal saline. At this first treatment 10 cc. of irrigant caused pain and no fluid returned upon aspiration. The treatment on the following day was supplemented by giving a pearl of amyl nitrate just preceding and six minutes following the instillation of nupercaine solution. Cholangiogram at this time showed, "no change in number or position of calculi within the duct." A continuous drip into the T-tube of solution G at the rate of 15 drops per minute was begun and the daily treatment with nupercaine solution and saline was continued. Twenty-four hours later there was a return upon aspiration of a thick green muddy-appearing fluid.

On the following day a tablet of nitroglycerine of 1/100 grains was given sublingually one minute after the instillation of 20 cc. of 1:500 nupercaine solution. Much more of the type of debris formerly removed was present in the aspirated fluid. Cholangiogram at this time shows, "a normal filling of the common duct and hepatic duct to the level of a non-opaque calculus. In comparison to the previous studies, this non-opaque calculus is lodged approximately one-half the distance through the distal common duct that was previously filled. I am unable to determine the presence or absence of calculi distal to this obstructing stone." It seemed possible that all but a single stone had passed into the duodenum but because the patient was seriously ill with an obstructive jaundice and a difficult problem to keep her physiology in balance, it was believed a second operation necessary to relieve the common duct of its remaining stone. The second operation was performed twenty-four days following the first one and thirteen days of daily treatments to attempt passage of the stones into the duodenum.

At the second operation, a complete and thorough examination within the common duct, including the trans-duodenal investigation of the ampulla of Vater and sphincter of Oddi, demonstrated the absence of a calculus. The patient made a rapid and complete recovery, the T-tube was removed one month after her second operation and she has remained completely well for two years. This case would emphasize perseverence as an important factor in the handling of these cases.

* * *

Case 4. H. S., male, 63 years of age. History of repeated attacks of right upper quadrant pains accompanied by jaundice for nine years; two attacks in the past month. At operation a thick-walled gallbladder containing flecks of cholesterol material and thin white bile was removed. The cystic duct was patent and meaured 1 cm. in transverse diameter. The common bile duct contained a considerable amount of black precipitated substance, like stone and gravel, packed into the ampulla and common duct. This material was freed and removed with difficulty by repeated use of stone forceps and flushing of the duct with saline solution. A T-tube was inserted so that the proximal short limb was into the entrance of the cystic duct and distal limb low in the common duct. Saline solution passed freely into the duodenum.

Eight days following the operation jaundice was getting progressively worse to a serum bilirubin of 3.2 mgm. A cholangiogram taken on this date showed. "An incomplete obstruction at the sphincter of Oddi compatible with a radio-opaque calculus at this level. The dye passes into the duodenal loop." A continuous drip of twelve drops per minute of solution G was started into the T-tube. Three days later with the serum bilirubin at 12.2 mgm. and most of the solution G drip returning about the T-tube, 30 cc. of 1:500 nupercaine solution was injected into the T-tube without discomfort to the patient. The tube was clamped for 15 minutes and then irrigated with saline solution. Aspiration from the T-tube recovered a large amount of dark green detritus and thick mucinous yellow bile followed by 200 cc. of old, bloody, non-odorous thin fluid. It was believed that this procedure accomplished the common duct cleaning and most probably opened the stump of the cystic duct and drained a sub-hepatic collection of fluid. A cholangiogram taken at this time revealed, "one notes a rapid passage of the dye into the duodenum. There is a spillover of the dye into the tissue adjacent to the cystic duct. No roentgen evidence of previously described stone." Rapid recovery followed this date with a complete subsidence of the jaundice and he left the hospital twenty-three days following the operation with the T-tube clamped for twelve hours at a time.

* * *

The vast majority of strictures of the extrahepatic ductal system are traumatic in origin. This is sufficient to stress the importance of meticulous care in the performance of cholecystectomy. In the surgical repair of stricture of the common bile duct meticulous search should be made for the distal segment for experience shows that reconstruction of the common bile duct with restoration of normal continuity has been followed by the highest incidence of satisfactory results. If the distal segment cannot

be demonstrated direct anastomosis of the proximal remnant of the duct to the duodenum has been followed by satisfactory results in the great majority of cases according to Walters[11] and only rarely has it been found necessary to utilize an isolated segment of jejunum in making the anastomosis following the Roux-Y principle. Walters[12] has failed to be impressed with the effects of loss of sphincter control at the anastomosis and reflux of duodenal contents into the biliary system but believes that obstruction at the site of anastomosis due to a contraction of the circular anastomosis is responsible for the attacks of cholangitis if they occur subsequent to operation. Permanent implantation of tubes should be avoided. They are useful splints for the anastomosis and to prevent contraction of the scar tissue during the first several months after operation. After that they often become obstructed with debris made up largely of bile salts and bile pigments. This is equally true of vitallium as well as those of rubber.

Enlargement of the head of the pancreas and tumors within the ampulla of the duct are a cause of biliary duct obstruction. If the lesion is inflamatory, it will usually respond to prolonged drainage of the common bile duct by T-tube. The radical operation for malignant lesions is not too satisfactory and the end results have been discouraging. When one considers the end results in relation to the risk of operation, the expense and the distress imposed, it seems reasonable to reserve the radical operation for carefully selected cases. In the remaining group, internal drainage will give temporary relief from the obstructive jaundice. The end results compare favorably with those who have had the radical resection.

SUMMARY

1. Pathology of the common bile duct is manifest by varying degrees of obstruction pressure changes within the ductal system, infection, and tumor.

2. Some discussion of each pathological entity is given with the acceptable treatment.

3. Case reports of four cases of overlooked common duct stone following choledochostomy and their successful treatment by use of solutions introduced into the T-tube.

4. A plea is made for early and meticulous gallbladder surgery.

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The Story Behind the Word

Some Interesting Origins of Medical Terms

Bistoury—The name for this type of incision knife comes from the old French term "bistouri" a dagger. This in turn is derived from the name of the City of Pistoria, now Pistoja in Tuscany, Italy, which was once celebrated for their manufacture.

Chillblain—A term composed of two words namely chill and blain. Chill being derived from the Anglo-Saxon "cycle" or cold and blain coming from the Anglo-Saxon word "blegen" meaning a boil, pimple or sore.

Physiology—Actually meaning an inquiry into the nature and origin of things and is derived from the Greek word "phusiologia." This in turn coming from the Greek words "phusis" or nature and "logos" or discourse.

Presbyopia—Literally means old sight and is derived from the Greek words "presbus" (old) and "ops" or "opa" (the eye).

Calf—This word as in "calf of the leg" is derived from the Gaelic word "calp" or "calpa" and also the Icelandic word "kalfi." The primary meaning being a lump.

Doctor—The title doctor primarily and originally meant a teacher and is derived from the Latin word "doceo," I teach.

Iodine—Obtains its name from the beautiful violet color of its vapor. The name is derived from the Greek words "ion" or violet and "eidos" or likeness.

Prostate—This gland secures its name from its anatomical location and descriptively means "the gland standing before the bladder." It is derived from the Greek words "pro" or before and "stasis" a setting or standing.

Speculum—This instrument is so named because of its function or use in permitting the diagnostician to look into body cavities. It is derived from the Latin speculum or mirror which in turn comes from the Latin word "specio" (I look at).

Arsenic—This poisonous mineral substance derives its name from the Greek word "arsenichos" meaning masculine or male and was so called because of its superior strength.

—Harry Wain, M. D., Mansfield, Ohio.

The Newer Antibiotics: A Brief Review of the Biological And Clinical Properties of Bacitracin, Polymyxin, Aureomycin, Chloromycetin and Neomycin

LOUIS WEINSTEIN, M.D., Ph.D.

THE discovery of penicillin is epoch making not only because it led to the development of an antibacterial agent of unprecedented potentiality in the alleviation of human suffering but also because it served as the spark that set off a determined, scientifically directed search for other agents active in the therapy of many infectious diseases; carefully planned research for antibiotics has almost entirely replaced their serendipitous discovery. So great have been the efforts in this field that the number of papers on this subject published each year number in the hundreds. Many substances with antibacterial or antiviral properties have been described in the last seven to eight years, and there are at least a hundred on which experimental work has been done. Most of these are not usable for one reason or another, but several have already been shown to be of practical value in the treatment of human disease and there are more which await only clinical trial to prove their merit. These antibiotic substances have been isolated from as wide and varied sources as plants, Actinomycetes, Streptomycetes, molds, bacteria, protozoa, and human tissues.

During the last three and one-half years, four new substances which have been tested in human infections have been developed. A fifth, recently reported by Waksman, shows promise in *in vitro* and *in vivo* experiments in animals and already has been used in man. Bacitracin, polymyxin, (Aerosporin), aureomycin (Duomycin), and chloromycetin (Chloramphenicol) have all been investigated during the past three years, and I shall attempt to summarize briefly the available knowledge concerning each of these drugs.

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AUREOMYCIN

Aureomycin is derived from the liquor in which Streptomyces aureofaciens, discovered by Duggar and Hesseltine, grows. It has been prepared as the hydrochloride and it is this compound that is used clinically. The drug has a pH of 4.5 and is stable for more than six months as a dry powder. In high concentration in distilled water at 37°C or 4°C, most of the activity is retained but in dilute solutions in broth, plasma or blood agar, a rapid decrease in potency occurs at 37°C and a somewhat slower fall at 4°C. It deteriorates rapidly in neutral or alkaline solution at room temperature. Whole blood and serum exert an antagonistic effect on aureomycin although actual killing of bacteria takes place if sufficient drug is present. The clinical effects of minimal blood levels of this drug are quite striking when its instability and antagonism by serum are considered; this is possibly due to a difference in the mode of action of the antibiotic agent in the body and *in vitro*.

In vitro and *in vivo* experiments in animals have revealed that the infectious agents listed below are susceptible to the action of aureomycin.

Gram Positive Bacteria	Gram Negative Bacteria	Gram Positive Cocci
B. cereus	E. coli	Strep. pyogenes
B. subtilis	A. aerogenes	Strep. fecalis
B. mycoides	S. pullorum	D. pneumoniae
Staph. aureus	P. vulgaris	
M. tuberculosis	K. pneumoniae	
	N. catarrhalis	
	S. typhi	
	S. gallinarum	
	Brucella	
	H. influenzae	
Gram Negative Cocci	**Rickettsia**	**Viruses**
N. gonorrheae	R. prowazeki	Lymphogranuloma venereum
N. meningitidis	C. burneti	
	R. rickettsi	Psittacosis group

Among the bacteria, Pseudomonas pyocyanea and Proteus vulgaris are practically unaffected by the drug. It also has no effect on the following viruses: poliomyelitis, B strain of influenza, canine distemper, rabies, Newcastle dis-

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ease, mumps, and Venezuelan equine encephalomyelitis. The most sensitive group of organisms are the aerobic spore-bearing bacilli. The action of aureomycin is bacteriostatic with the amounts used in animal or human infections. It has been estimated that from 20 to 50 times more drug is required to produce a bactericidal effect than is necessary to affect bacteriostasis. No aureomycin resistant or dependent strains have been developed *in vivo*; it is possible to decrease the sensitivity of microõrganisms to this agent *in vitro*, however. S. typhi has been made four-fold and Proteus vulgaris 533 times more resistant to aureomycin by repeated transfer in drug-containing media. There is no evidence of cross resistance between aureomycin and other antibiotics such as penicillin and streptomycin.

When aureomycin is given by the intramuscular or oral route, it appears in the urine within the first hour and the maximum amount is excreted in the next four to eight hours. Following a single oral dose of 0.5 to 0.75 gm. about 13.5 per cent can be recovered during the following 55 hours. In patients receiving 1 to 2 gms. daily by mouth, the maximum urinary concentration is about 250 gamma per ml.; excretion is prolonged and antibacterial activity is still demonstrable three or four days after the last administration of the drug. Aureomycin is excreted in the bile. In individuals with normal meninges, very little or none of the antibiotic agent can be detected in the cerebrospinal fluid when the drug is given orally or parenterally. Passage across the blood-brain barrier in instances where the meninges are inflamed is irregular but, at best, appears to be quite poor.

Aureomycin may be administered either parenterally or by mouth and is absorbed quite rapidly by either route. It is difficult to define a single scheme of administration which will suffice for all treatable diseases; the quantities used in various infections are discussed below. However, the following general dosage schedule has been suggested: In severely ill patients, a "priming" dose of 1/6 the total daily amount is given hourly for three hours, and then administered at four-hour intervals until the temperature has been normal for twenty-four hours. After this the total daily quantity is reduced by one-half or to 30 mgm. per kilogram of body weight; this is divided into four doses and given every six hours. In moderately severe infections, 30 mgm. of the drug per kilogram of body weight divided into four or six equal parts given at four to six-hour intervals is recommended.

The treatment of typhoid fever with aureomycin has yielded equivocal results and evaluation of the effectiveness of the drug is very difficult. Four patients with this infection who were given 10 mgm. of the antibiotic agent per kilogram of body weight parenterally showed no alteration in their clinical course, the blood cultures remaining positive throughout therapy. In another group of five patients treated orally, four children cleared their bacteremia in one to two days (treatment started between the fifth and tenth day of illness) and a man 60 years of age showed persistence of bacteria in the bloodstream throughout the entire course of therapy. The urine and stools of all of the patients were free of S. typhi after the second day of treatment.

Aureomycin, 1 to 3 grams given over a period of one to two days, is effective in curing acute gonorrhea in males. When compared to a single injection of 300,000 units of penicillin given intramuscularly in a prolonging agent, however, the over-all results are distinctly inferior. Failures are most frequent in instances where the drug is given for only one day with a total dose of only 1.0 to 1.5 gms. Treatment on two successive days produces a response which is more like that which usually follows an adequate dose of penicillin.

Pneumococcal pneumonia has been found to respond quite favorably to the administration of aureomycin in a dose of 0.5 gms. given every six to eight hours for five to ten days depending on the severity of the pneumonitis. Subjective and objective improvement occurs rapidly and defervescence may be complete in eighteen to thirty-six hours after the beginning of treatment.

Urinary tract infections have been treated with aureomycin in several clinics. A dose of 0.5 gms. twice a day for seven days as initial therapy and 2 gms. per day in cases requiring re-treatment because of recurrent infection has been recommended. In general, there is a marked and rapid diminution in pyuria during therapy. Dysuria, nocturia, and frequency diminish in most cases concurrently with the disappearance of pyuria, and sterilization of the urine takes place during the course of treatment in most patients. In some individuals Proteus, Pseudomonas, and uncommonly E. coli may appear for the first time or persist in the urine during aureomycin administration. In many cases, infection with either the initial type of organism or with a different species recurs within a few days after cessation of therapy. Proteus and Pseudomonas are not at all eradicated from the urine or are eliminated only with great difficulty. As a matter of fact, the data obtained in one study seem to indicate that Proteus may flourish while aureomycin is being given. In cases of chronic urinary tract infections, good results of a permanent nature are, as a rule, infrequent, but temporary relief may result in about two-thirds of the cases. The problems that arise in the treatment of urinary tract infections with aureomycin are quite iden-

tical with those present when sulfonamides or streptomycin are used. In instances where mixed infections, chronic obstruction, or foreign bodies such as stones or indwelling catheters are present in the urinary tract, permanent results are very difficult to obtain. The necessity for surgical treatment to relieve the obstruction to the flow of urine is just as great when aureomycin is administered as it is when any other chemotherapeutic agent is given.

Aureomycin has been used successfully in the treatment of lymphogranuloma venereum. Good results have been obtained with the administration of 0.3 gms. orally or 20 mgs. intramuscularly four times a day. The buboes, secondary infections, and the acute reaction disappear rapidly with the administration of the drug. As might be expected, the rectal strictures are not at all affected by this therapy, but acute inflammatory reactions in the rectum and the acute proctitis which may occur at times are very beneficially influenced. It has also been noted that aureomycin will heal the ulcerations of granuloma inguinale.

A number of cases of Rocky Mountain Spotted Fever have been treated with aureomycin and the response has been excellent. Two dosage schedules are suggested; 30 mgs. per kilogram of body weight in a twenty-four-hour period divided into four doses; or, 0.3 to 0.7 gm. orally every six hours. In most of the cases of this infection treated with this drug defervescence has been complete in from twelve to seventy-two hours, and the disease has run a markedly shortened clinical course.

One infection in which aureomycin appears to produce quite striking improvement is so-called "virus pneumonia." Although it is difficult, in many cases, to interpret the results produced by the administration of the drug, since the entire course of the disease may be short-lived, a number of instances of severe "virus pneumonia" have been reported in which treatment with aureomycin has produced very rapid defervescence and disappearance of clinical symptoms and signs. Several dosage schemes have been used; an initial dose of 1.5 gms. followed by 1 gm. every six hours orally; or, 1 gm. every six hours for the first day and 0.5 gm. every six hours thereafter until the temperature has been normal for two or three days. Many of the cases of this disease that have been treated with aureomycin have been verified by the demonstration of cold agglutinins and agglutinins for streptococcus MG.

Nineteen cases of Q fever have been treated with aureomycin. In four patients in whom intramuscular therapy with small doses was employed, the results were not satisfactory. In fifteen individuals who were given the drug orally, improvement occurred in all but one promptly after the commencement of therapy; the fifteenth, a chronic infection with C. burneti, failed to respond to large doses. Relapses occurred in two patients in the orally treated group following cessation of therapy; a second course of aureomycin produced complete defervescence in both.

Aureomycin has been claimed to be effective in various infections of the eye. Ocular disease produced by Strep. pyogenes, Staph. aureus, D. pneumoniae, K. pneumoniae (Friedlander bacillus), N. gonorrheae, Pseudomonas pyocyaneus, Proteus vulgaris, H. influenzae, Morax-Axenfeld bacillus, and N. meningitidis are all said to be susceptible to treatment with this drug. In most instances, the local application of a 0.5 per cent solution of aureomycin borate is thought to be satisfactory. Several viral infections of the eye such as inclusion conjunctivitis, trachoma, lymphogranuloma venereum, herpes simplex corneae, and follicular conjunctivitis have been reported as responding to the local and/or parenteral administration of aureomycin. This antibiotic agent has also been suggested for trial in epidemic keratoconjunctivitis, herpes zoster, non-hemolytic streptococcal, H. ducreyi, syphilitic, and Brucella infections of various parts of the eye, and disease produced by Moraxila duplex, as well as marginal keratitis and uveitis. The drug appears to be without value in erythema multiforme, ocular pemphigus, Parinaud's conjunctivitis, sympathetic ophthalmia, vernal conjunctivitis, molluscum contagiosum, Mooren's ulcer, and Streptothrix concretions.

The effectiveness of aureomycin therapy in human brucellosis due to Brucella melitensis has been reported recently. Twenty-four patients with this infection were treated with 0.5 gms. four times a day for two weeks. Immediate therapeutic results surpassed those obtained with any other agent. Relapse of the infection with recurrent bacteremia after cessation of treatment has been noted, however.

A miscellaneous group of infections of which one or a few cases have been treated with aureomycin and in which good results have been obtained are the following: Meningococcemia, E. coli bacteremia and brain abscess, nonspecific urethritis due to the pleuropneumonia group of organisms, Staphylococcal infections of the skin, breast, and brain, tuberculous sinuses of the skin, Strep. fecalis meningitis, and endocarditis, and Brill's disease. The drug has been found ineffective in measles, mumps, whooping cough, polio-encephalitis, noma, and erythema multiforme.

No serious toxic effects have been noted with aureomycin. When amounts as large as 4 gms. are administered on the first day followed by 2 gms. daily thereafter, the commonest complaint is looseness of the bowels with frequent bulky and soft stools; true diarrhea is uncommon. Nausea and occasionally vomiting may occur

after one or more doses in some patients. In individuals with cystitis a disagreeable sensation of "drawing" or "squirming" in the pelvis has been reported; these abnormal sensations may be related to the high acidity of the urine during ingestion of large quantities of the drug. Intramuscular injections produce considerable pain at the site of administration. No anemia, leukopenia, renal irritation, liver impairment, rash or fever has thus far been reported following the administration of aureomycin.

In animals the administration of aureomycin does not seem to interrupt the development of immunity if massive doses of infectious material are injected and drug treatment started before symptoms appear. If relatively small doses of infecting agent are given and antibiotic administered before the development of any manifestations, an immune response may or may not develop. One of the sequelae of aureomycin treatment which must be kept in mind constantly is the appearance of new infections: Proteus vulgaris infections of the urinary tract which seemed to start after administration of the drug have been reported by two investigators.

CHLOROMYCETIN

Chloromycetin or Chloramphenicol is produced by Streptomyces venezuelae n. sp., isolated by Burkholder from Venezuelan soil; the organism is related to S. lavendulae. Ehrlich and his coworkers first demonstrated the antibiotic agent in cultures of this organism. The drug is a neutral compound, withstands boiling in distilled water for five hours, and is unaffected by standing at room temperature for more than twenty-four hours in aqueous solutions over the pH range 2 to 9. Its solubility in water at 25°C is about 2.5 mgm. per ml. and it is also soluble in propylene glycol, methanol, ethanol, butanol and acetone. Chloromycetin has been produced synthetically.

Chloromycetin is effective in the following experimental infections in animals or embryonated eggs:

Effective	Questionably Effective	Not Effective
K. pneumoniae	Newcastle Virus	Malaria
S. paradysenteriae (Flexner)		Syphilis
S. paradysenteriae (Sonne)		Guinea Pig Tuberculosis
Psittacosis virus		Type A. Influenza Virus
R. prowazeki		Virus of St. Louis Encephalitis
Lympogranuloma venereum		D. pneumoniae
Borrelia recurrentis		Strep. pyogenes

In vitro studies show chloromycetin to have no antifungal or antiprotozoal effects. It is only about one-tenth as active as streptomycin against streptomycin sensitive strains of M. tuberculosis, one to two times more effective than streptomycin against B. mycoides and Staph. aureus, and two to sixteen times more efficient against Brucella, S. typhi, E. coli, H. pertussis, and K. pneumoniae. It is only one-fiftieth as antibacterial as penicillin against Staph. aureus but is seven to thirty-six times more active against gram negative organisms. The synthetically prepared material has the same degree of Rickettsiostatic, virustatic, and bacteriostatic effect *in vitro* and *in vivo* as does the naturally occurring compound.

Chloromycetin is well absorbed from the gastro-intestinal tract and may be given either orally or parenterally; serum levels are roughly identical with either route. This antibiotic substance is excreted or inactivated fairly rapidly; less than 10 per cent appears in the urine. It is bound to the extent of about 45 per cent by serum albumen. A single dose in animals is excreted or destroyed in about six hours. In man, chloromycetin can be given orally in single doses of 2 grams or in daily doses of 1 gram for ten days without any untoward results. Relatively high levels are present in the blood thirty minutes after administration of the drug; it is present in the urine at the same time and reaches a maximum level in about eight hours. About 10 per cent of administered chloromycetin is recoverable in active form in the urine. Blood levels after a single dose are well above 10 gamma per ml. at two hours and above 5 gamma per ml. at the end of eight hours. Penetration of the normal meninges does not take place; studies in cases of meningitis are still too inadequate to allow any statement.

Among the bacterial diseases which appear to respond to treatment with chloromycetin are typhoid fever and urinary tract infections. One group of ten patients with typhoid fever treated with this drug has been recorded in the literature. The following dosage was used; 50 mgm. per kilogram of body weight as the initial quantity followed by 0.25 gm. every two hours until the temperature became normal and the same amount continued every three or four hours in the absence of fever for the next five days. Evidence of improvement was noted usually in twenty-four hours and the average time required for complete defervescence was 3.5 days. Bacteriologic studies revealed eradication of the organisms from the blood stream immediately subsequent to the administration of the first dose of the drug, and sterile urine throughout the course of the illness; stool cultures still contained S. typhi at the time of discharge from the hospital in three cases. Relapse occurred in two individuals after ten and sixteen days without fever but both responded well to a second course of therapy. One instance of intestinal perforation and another of hemorrhage from the

bowel were seen in this group. In our own clinic, a 20-year-old girl with typhoid fever to whom chloromycetin was first administered orally on the tenth day of illness showed a return of temperature to normal eighteen hours after institution of treatment and rapid clearing of bacteremia although urine and stool cultures were positive late in the course of the disease.

Chloromycetin is of value in the management of urinary tract infections but is of about the same order of efficiency as the sulfonamides, streptomycin and aureomycin. The administration of two grams, 0.5 gm. every six hours, a day leads to clearing of pyuria and rapid disappearance of urinary tract symptoms in most cases. Infections with Pseudomonas pyocyaneus show little or no response. The presence of mixed infections, chronic obstruction and foreign bodies in the urinary tract imposes the same difficulties in producing complete cures as when any other antibacterial agent is used.

Rocky Mountain Spotted Fever has been treated successfully with chloromycetin. An initial dose of 75 mgm. per kilogram of body weight administered orally in two or three parts at hourly intervals followed by 0.25 gms. every three hours for those less than 16 years of age and 0.5 gm. every three hours for older individuals has proved effective. Abatement of symptoms and cessation of spread and recession of the rash usually take place within forty-eight hours after initiation of treatment. Defervescence is accomplished usually within seventy-six hours and convalescence is established on the third day of therapy. Good clinical results have also been produced with chloromycetin in the management of scrub typhus in twenty-five patients. The first oral dose in this group was about 50 mgm. per kg. of body weight followed by 0.2 to 0.3 gm. every two to four hours for a variable time. A beneficial effect was observed after only twenty-four hours of therapy in some cases.

The two viral infections which appear to respond to chloromycetin are "virus pneumonia" and lymphogranuloma venereum. The administration of 0.5 gm. orally every four hours seems quite effective in the viral pneumonitis. The results of therapy are of about the same order as those produced by aureomycin.

No toxic effects have yet been noted in patients receiving chloromycetin by either the oral or parenteral route. The drug is extremely bitter; in children who cannot take capsules the taste may be masked by very sweet vehicles or the antibiotic agent given parenterally.

POLYMYXIN

Polymyxin (Aerosporin), a polypeptide produced by Bacillus polymyxa, was first isolated by Stansly, Sheperd and White. This drug has a remarkable specificity for gram negative bacteria. Its bacterial spectrum is presented below:

Sensitive Organisms	Non-sensitive Organisms
A. aerogenes	B. mycoides
Br. abortus	B. subtilis
E. typhosa	Cl. welchii
E. coli	C. diphtheriae
H. Influenzae	D. pneumoniae
K. pneumoniae	E. rhusiopathiae
N. intracellularis	M. tuberculosis
P. multocida	Staph. aureus
P. vulgaris	Strep. pyogenes
Ps. pyocyanea	Strep. fecalis
S. suipestifer	Strep. viridans
S. enteritidis	
S. paratyphi	
S. schottmulleri	
S. pullorum	
Sh. dysenteriae	
Sh. paradysenteriae	
Sh. sonnei	
Sh. gallinarum	
V. cholerae	

Polymyxin is therapeutically effective in experimental infections in mice due to K. pneumoniae, H. pertussis, and P. multocida. The drug has been found to be definitely more effective than streptomycin against certain gram negative bacteria and is from two to eighty times more active than the latter agent against susceptible organisms. Its activity is primarily bactericidal while that of streptomycin is bacteriostatic.

Pharmacologic studies of polymyxin have been restricted, in the main, to animals. This antibiotic substance is not absorbed from the gastrointestinal tract and when given parenterally disappears rapidly. In normal animals it is not detectable in the cerebrospinal fluid, bile, or urine. In man it cannot be found in the spinal fluid in the presence of meningeal inflammation.

There is only one report in the literature on the clinical application of polymyxin. Ten cases of pertussis in very young children were treated with 0.8 mgm. per kilogram of body weight given four-hourly. Although a very definite response to treatment in the first forty-eight hours is reported, the results appear somewhat doubtful when inspected closely.

Histamine-like reactions, hypesthesia, and fever have been observed during the course of polymyxin therapy; these are thought to be due to the presence of impurities rather than to the drug itself. The one very serious toxic effect produced by this antibacterial agent is damage to the kidney. All specimens of polymyxin that have been used produce varying degrees of renal tubular dysfunction varying in severity from fixation of urine specific gravity alone to any combination of oliguria, albuminuria, cylindruria, hematuria, pyuria, azotemia and depressed renal function. Because of this serious

nephrotoxicity the clinical use of polymyxin is contraindicated at present.

BACITRACIN

Bacitracin, an antibiotic agent first described in 1945 by Johnson, Anker and Meleney, is produced by a particular strain of B. subtilis ("Tracy I"). It is neutral in reaction, water soluble, non-toxic and relatively heat stable (100°C for fifteen minutes). It is soluble in water, methanol, ethanol, isopropanol, n-butanol and cyclohexanol but not in other organic solvents. The drug is stable for as long as a year when stored at 0° to 5°C but loses 30 to 50 per cent of its activity when kept at room temperature for two weeks.

Because of evidence of nephrotoxicity the systemic administration of bacitracin has been quite limited. Injury to the kidney seems to be produced only by certain batches of the drug and appears to be due to by-products of manufacture rather than to the antibiotic substance itself. In spite of this a number of human beings have been given this drug systemically. Solution of bacitracin in 2 per cent novocaine in normal saline and administering alkali so that the pH of the urine is maintained at 6 or more is said to reduce the incidence of harmful renal effects. No local toxic or irritating effects have been observed.

Bacitracin has proved effective against most strains of hemolytic and non-hemolytic Streptococci, coagulase positive Staph. aureus, D. pneumoniae, N. gonorrheae, anaerobic cocci, the organisms of gas gangrene, Cl. tetani, C. diphtheriae, diphtheroids, S. pallida, the spirochetes responsible for infections of the mouth, Actinomyces, and E. histolytica. Little or no action has been demonstrated on the aerobic gram negative non-sporulating bacilli such as E. coli, Proteus vulgaris, Pseudomonas pyocyanea, etc., some gram positive organisms and fungi. A few strains of H. influenzae have been found sensitive. Organisms resistant to penicillin and sulfonamides may be very susceptible to bacitracin; the contrary is also true.

Clinically, bacitracin has been used most extensively in localized, superficially located infections. Two preparations are recommended for use in surgical infections: (1) a water solution containing 200 to 400 units of the drug for injection into furuncules, carbuncles, and deep and superficial abscesses; and (2) a water soluble ointment containing the same amount of the antibiotic substance for treatment of open lesions such as ulcers. Various affections of the skin—impetigo, ecthyma, folliculitis, infected eczematoid dermatitis, vesicopustular eruptions, furunculosis, pustular psoriasis and acne varioliformis have been treated quite successfully.

The preparation recommended for treatment of this type of disease is an ointment containing 480 units of drug per gram of carbowax-propylene glycol base. A rare instance of contact dermatitis may be observed.

The effectiveness of bacitracin in some ocular infections has been recorded. Acute and chronic conjunctivitis, acute keratoconjunctivitis and corneal ulcer have been found, in the main, to respond to the local application of a solution containing 1000 units of the drug per ml. of physiologic saline.

Meleney, et al., treated 105 patients with surgical infections by the systemic administration of bacitracin. A large proportion of these cases had failed to respond to other forms of treatment. Favorable results were produced in cellulitis, deep abscesses, infected accidental wounds, synergistic gangrene, meningitis and human bite infections. The most striking effects were observed in cases of synergistic gangrene in which a destructive process of many months' duration was halted by the antibiotic agent within twelve hours of its first application. Orally administered bacitracin seemed to exert some degree of beneficial activity in ulcerative colitis and regional ileitis although no definite conclusions were warranted.

NEOMYCIN

The most recently described antibiotic is neomycin. This agent was isolated by Waksman and Lechevalier from cultures of Streptomyces fradiae, a soil inhabitant. It is active against numerous gram positive and gram negative bacteria but has no antifungal effect. *In vivo*, it is also effective against both streptomycin-sensitive and resistant gram positive and negative organisms. It has, thus far, not exhibited any toxicity for animals. It appears to possess considerable activity against M. tuberculosis and other Mycobacteria; in some cases its effectiveness is greater than that of streptomycin. Development of lack of sensitivity to this new substance has not yet been demonstrated.

Neomycin has been applied clinically only to a limited extent; if it can be given to man without producing serious toxic effects it may be promising in the treatment of cases of tuberculosis and other infections in which streptomycin-treatment has resulted in the development of drug-resistant strains of bacteria.

DISCUSSION

The review of the clinical properties of the antibacterial agents presented above reveals progress in two directions: (1) The new chemotherapeutic substances are effective in infections which in the past have generally been untreatable by any specific means, e. g., the psittacosis-lymphogranuloma virus group of diseases, "virus pneumonia," typhoid fever, scrub typhus, etc.; (2) the most recently described antibiotics are active in cases in which very adequate chemotherapy is already available as, for example, pneumococcal pneumonia, gonorrhea, urinary

tract infections, etc. In the first group no problems are raised concerning the choice of drug with the possible exception of choosing between aureomycin and chloromycetin, since both seem to be equally effective in the viral and Rickettsial infections. In the second group, however, the matter of employing the most effective agent is much more involved; thus while both aureomycin and penicillin will cure disease produced by the pneumococcus, the latter is the agent of choice, at the moment, if for no other reason than that it is relatively cheap, and successful clinical experience with it is far greater than with any of the other drugs. In urinary tract infections, treatment with one of the new antibiotic chemicals may be ill-advised since the process may be due to an organism which is not very sensitive to it; e.g., Pseudomonas pyocyaneus and Proteuis vulgaris are little, if at all, affected by aureomycin.

The tendency for physicians to employ a drug such as aureomycin which has a fairly wide antibacterial spectrum in cases in which no attempt to establish a definite etiologic diagnosis is made may sometimes prove disastrous because the agent may be completely ineffective. The use of one antibiotic after another, in hit and miss fashion, in the treatment of a case of infection may eventually produce a favorable response in some instances but is a dangerous procedure since it often delays proper therapy too long, results in unnecessary hypersensitization, may lead to the appearance of resistant organisms, and produces a false sense of security. Since aureomycin and chloromycetin have become readily available we have had the opportunity of studying several patients who failed to respond to treatment with penicillin followed by streptomycin, aureomycin, and finally chloromycetin; in all instances these individuals had such untreatable diseases as rheumatic fever, virus infections, or lymphomas. While the exhibition of three or four agents in succession or simultaneously is still feasible, although most undesirable at present, one cannot but wonder what will happen when a dozen or more effective antibacterial drugs become available, as they well may, in the next ten or fifteen years. Obviously, treatment with all of the drugs, together or separately, would be impossible.

Unless a chemotherapeutic substance which is active against all bacterial and viral infections is developed, and this seems very unlikely in view of what is known concerning the differences in the metabolic activities of various microörganisms, the need to establish exact etiologic diagnoses will increase as the number of antibacterial drugs multiplies. This will be particularly true if the agents which are produced in the future have the specificity characteristic of penicillin, streptomycin, bacitracin, or polymyxin. The wholesale use of the antibiotic substances without establishing the cause of an infection and, in truth, often for the treatment of obscure fever, can only be decried. The time required to determine the etiology of an infectious disease is often time saved in the total course of an illness because the risk of application of the wrong agent is reduced and, even more important, the diagnosis of fevers due to infectious causes is not delayed too long by waiting for chemotherapy to produce an effect. While specific situations may demand the immediate application of an antibiotic substance in the presence of an obvious critical infection, it is most important to carry out the procedures necessary to establish a definitive diagnosis before a drug is given even though treatment is applied before the results are available; the time required to do this is so short that the delay in the exhibition of chemotherapy is negligible. The need for laboratory study of cases of infection has increased, rather than decreased, with our improved methods of therapy; information concerning the bacterial flora of patients who are receiving antibiotics is important not only at the inception but also during the entire period of treatment in order to check the response to therapy and to detect any changes in bacterial populations that may result in new infections due to organisms which are not sensitive to the antibacterial or antiviral agent being used.

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Fibrositis and Segmental Neuralgia

JOSEPH M. STRONG, M.D.

ONE of the most common complaints confronting physicians in general practice is low back pain or pain in the extremities. It is also true that many of these patients leave the doctor's office undiagnosed and treatment is often disappointing. Frequently these patients make the circuit of various doctors, finally ending up with some charlatan. Truly these patients are perplexed, but no more so than the physicians who have diligently tried to meet their problem only to realize failure. I venture to say that there are no more than a handful among you readers who have not lost sleep attempting to speculate on the cause of some patient's backache which has been resistant to treatment.

In the past few decades, many advances have been made which have reduced the group of undiagnosed back conditions. After one has eliminated the congenital deformities, mechanical instabilities, ruptured discs, skeletal injuries, back pains referred from other systems, and other known causes of back pain, there still remains a certain group of cases with characteristic signs and symptoms which have been classified as intramuscular fibrositis. The discussion in this paper will be confined to fibrositis of the back and its secondary effects in the extremities due to referred pain. The term segmental neuralgia is used to describe these secondary changes.

TYPES OF CASES FALLING INTO THE FIBROSITIC SYNDROME GROUP

For the purpose of this discussion, cases of the fibrositic syndrome are classified on the basis of history and symptoms into five groups, as follows:

1. Patients of this group have had backache as long as they can remember. The backache is not severe enough to complain about but recently the pain, described as dull and continuous, is now troublesome. At first heat and massage were beneficial but now treatment seems useless. Chiropractic manipulations helped for a few days at a time but now these are also worthless. Damp cold weather increases the intensity of the pain in most, but in some, weather changes are not a factor. On arising in the morning, the back is stiff. Some patients have difficulty in getting out of bed but once they do, and move about, the stiffness gradually subsides and the pain completely disappears. Sitting in a chair for long periods produces considerable back stiffness. Movement and mild exercise seem to give some relief. Occasionally some patients set their clocks to awaken them several times during the night, in order that they may move about to prevent severe stiffness and pain in the morning. Frequently, attacks of acute pain arise in the back with associated dull ache in one or more of the extremities, such as the shoulder, hip, or arm. These attacks are so severe at times as to confine the patient to his bed. The acute attack usually subsides in time with or without treatment.

A number of patients in this group have had several abdominal or back operations without securing any benefit. The acute attacks of referred pain have been misdiagnosed for abdominal disorders. They have had pain for many years without having received much benefit from treatment. They are miserable and have developed somatopsychic symptoms. Emotional stress appears to increase their pain.

The younger patients (the youngest at present which I have seen was 14 years old) will often trace their first backache to a traumatic incident, such as a fall, severe jarring, or a period of chilling. The older patients have usually forgotten the time of onset of their back condition.

2. The second group of patients notice the onset of back pain following a rapid muscular movement, such as:

(a) Reaching down to pick up an object and, on coming up, a sudden pain developed in the lower back which prevented him straightening up.

(b) Making a sudden twist to reach for something.

(c) Suddenly interrupting a smooth movement, for example; During the act of shoveling, the patient is distracted and abruptly stops his stereotyped movement.

In most of these cases, the trauma is usually too trivial to produce sprains or strains. This group presents a troublesome problem to the industrial physician.

There is no complaint of referred pain into

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the extremities. The pain is usually well localized to the lower back, at first diffusely, but later, to a surprisingly constant, well-defined area.

Many of these patients respond to manipulations or procaine injections into the tender area. They decry the physician who has treated them with back strapping, diathermy, massage, and other forms of treatment with no benefit, and will state that one manipulation of the back by a chiropractor immediately relieved him of his pain. Immediate cures are few indeed, but they do occur.

The pain is so intolerable at times that the patient may drop to the floor at the occurrence of the attack and will scream if attempts are made to move him. Occasionally, I have had to inject these patients with procaine in the back before they could be moved into bed.

One important point is usually missed. If questioned carefully the majority of these patients will admit that several days or weeks before their attacks, their backs did not feel quite right or that there was vague stiffness which they felt was not severe enough to mention.

3. The third group is the same as the second, except there is no history of minor trauma preceding their acute attacks. The pain may be noticed quite vaguely some morning on arising and grows in intensity. The patient may show sciatic scoliosis and muscle spasm. There may be a list when he walks. However, he gives no history of referred pain into the extremities. This type of patient responds quite well to manipulation, procaine injection, and heat and massage, or, if left alone, the attack will subside spontaneously in time.

4. The fourth group includes patients of the second and third group in which there is radiation of pain into the extremities. The referred pain is usually more or less diffuse but roughly corresponds to the distribution of a nerve root. The patient on close interrogation will state that there is a "gnawing feeling about the hip, knee, calf, etc." The symptoms of many of these individuals may so closely resemble a ruptured disc that operations for removal of discs may be undertaken when no such pathology is present. Yet, the patient may be improved. This cure, I attribute, to the muscle stripping which is necessary during the operation.

5. The fifth group is the segmental neuralgias. Many of these patients with painful shoulders, hips, knees, thighs, etc., have undergone careful and thorough examination and no diagnosis could be made. Very often, they may be benefited by stellate ganglion or paravertebral blocks. Most dramatic of all are the long standing cases which respond to procaine injection of the so-called "trigger area" in a muscle. Often, these patients are treated as neuridites but there is no neurological evidence of such a condition.

The fibrositic syndrome must not be confused with the psychogenic backache. The psychogenic backache may superficially resemble a fibrositic syndrome but on the whole, the history and findings given above are not present. Patients with the fibrositic syndrome do not respond to psychotherapy.

PHYSICAL FINDINGS

1. Presence of tender areas in remarkably well defined locations in the back. Well defined fat nodules described in the literature are not to

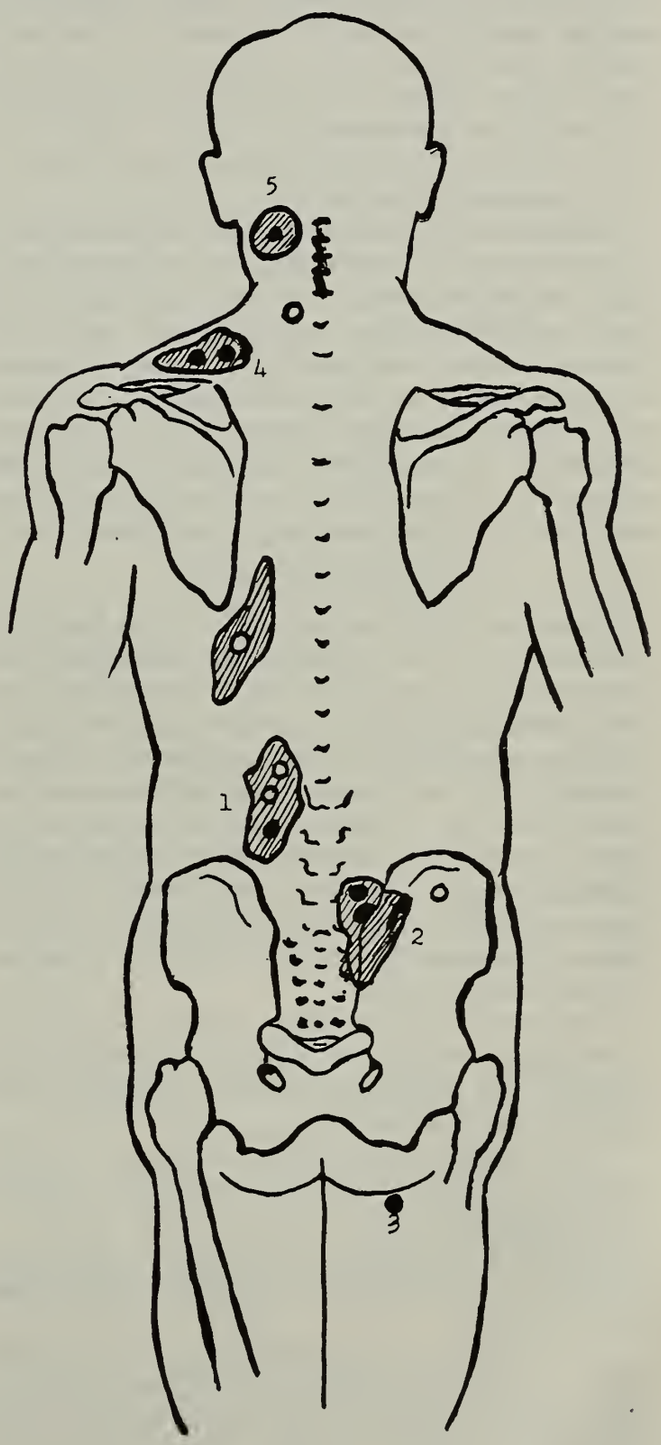


FIGURE 1

Figure 1. Schematic drawing showing most frequent sites of myalgic areas. Black dot represents most frequent site and circle represents less frequent areas.

be confused with the tender areas or nodules in the muscles.

2. Apparent complete absence of systemic infection.

3. Negative laboratory tests although Steinberg reports that creatinuria is a common finding.

The most common locations of tender areas are: (Figure 1)

1. Over the transverse processes of the first to the third lumbar vertebra, most often over the third.

2. Over the erector spinal group at the insertion into the sacrum or near the posterior superior iliac spine.

3. At the origin of the hamstring muscles at the ischial tuberosity.

4. Trapezius muscle above spine of the scapula.

5. Suboccipital region.

Other painful areas are present less frequently.

The presence of tender nodules in muscles has been denied by many. If one looks patiently and persistently for these lesions, he soon becomes aware that these areas are abnormal as compared to the surrounding muscle. There are certain areas in normal muscle which are sensitive. In unilateral myalgic lesions the difference is remarkable and impressive. The sensitivity is much greater in the affected area.

THE FIBROSITIC LESION

Stockman considered the cause of the fibrositic syndrome to be an inflammatory hyperplasia of intramuscular connective tissue. Attempts have been made by others to confirm this, but it is safe to state that no one has conclusively demonstrated that such lesions are inflammatory or hyperplastic in nature. Clinical experiments which I conducted by using a myotome for muscle biopsies designed by Shank and Hoagland, failed to reveal any evidence of inflammatory fibrous tissue. Specimens were taken from the regions of the myalgic lesions.

The term fibrositis has its basis on unconvincing and unconfirmed clinical or experimental evidence and should not be used to describe this group of back disorders.

The presence of an inflammatory or hyperplastic fibrous lesion is not necessary to explain the palpable nodules.

Micheal Kelly states, "the fibrositic syndrome consists of a muscular lesion with wide spread reflex effects."

The nodules in the generalized type of case are by no means constant in location. One day they can be palpated in one area and the next day in some other. If they were composed of inflammatory fibrous tissue, surely they would persist. Following procaine injection into the myalgic areas, very often the "nodules" completely disappear. I have had several patients with shoulder pain which showed these "nodules" in the trapezius muscle. Following stellate ganglion block, the lesions were very difficult to define. The same is obtained with procaine injection into the affected muscular area. The application of heat in the form of diathermy, on occasions, may temporarily abolish the nodules. On the other hand, in some patients, heat increases their pain and the nodules are more pronounced. It is my opinion that these areas are muscle segments in a spastic state.

MECHANISM OF PRODUCTION OF THE MYOSPASTIC SYNDROME

The author feels that the lesion present in these cases is actually a localized spasm of muscle usually at the myotendinous junction in locations which have an abundant supply of nerve endings.

To explain this lesion, it is necessary to have a knowledge of pain production: the sympathetic system with its effect on circulation and its involvement in visceral and somatic reflex pain. There is insufficient time for a lengthy discussion of these subjects, but certain salient facts will be mentioned.

1. Insufficient knowledge exists as to how pain is produced or how muscle is innervated with pain-producing nerve fibers. What physicochemical process stimulates these fibers is not known. However, it has been shown that as a result of muscle anoxemia, muscle pain becomes prominent. This is seen in extremities with inadequate blood supply as in intermittent claudication. Lewis suggests that there is production of a pain-producing substance as a result of muscle activity. Whether the pain fibers are components of the sympathetic system alone has not been satisfactorily proven. The sympathetic system, however, does play a part.

2. We know that vasomotor control is carried out by the sympathetic system and if vasoconstriction is sustained, pain soon is felt, i. e., as in Reynaud's disease or freezing of the extremities. Leriche has presented his theory of "circus" mechanism in production of pain following trauma. The involvement of the sympathetic system is clearly explained. A good example is the relief of pain and swelling following local procaine injection into a sprained ankle. Very often the pain and swelling persists for months after the torn or stretched ligaments have healed. The elimination of pain in causalgia by stellate ganglion blocks or paravertebral sympathectomy is recognized by most physicians. The sympathetic system with its vasomotor effect is a participating factor in the production of the syndrome under discussion.

The vasomotor effect in the skin due to sudden changes in temperature of the surrounding air increases the discomfort in cases of fibrositis.

3. The reflex mechanism of visceral referred pain is now accepted. One need only to recall the shoulder pain experienced when the diaphragmatic pleura is inflamed or the referred pain in

the arm in coronary disease. This referred pain from viscera is accomplished by means of the sympathetic system.

4. Referred pain down the extremities from deep somatic structures has been proved by many workers; Steindler, Lewis, Kellgren. By means of injection of six per cent hypertonic saline into muscles of the back, Lewis and Kellgren produced pain in remote areas. They demonstrated that as a result of irritation of trauma of muscle, pain could be referred to the peripheral distribution of the somatic nerve. This referred pain does not correspond exactly with the anatomical distribution of skin dermatomes. The muscles about the interspinous ligaments were injected in their experiments.

The experimental work above corresponds closely with the clinical findings in this group of cases. In many patients, palpation of the deep painful areas will produce the referred pain of which the patient complains. During procaine injections, if the injecting needle strikes the reflex producing area, the referred pain is accentuated immediately. Procaine injections (5 cc.) completely abolish the local and referred pain. Some patients are completely cured with one injection and with others there is a recurrence of the pain in several hours, necessitating further injections.

Let us trace a typical referred pain syndrome. (Figure 2)

A calculus anywhere along the ureter will produce referred pain into the external inguinal ring and occasionally the testicle. Now this structure is supplied by nerve fibers of spinal cord segments, L_1 and L_2. As a result of this referred pain, the diagnostician, from past experience, associates a ureteral disorder and investigates along these lines. However, a similar picture presents itself when there is involvement of the deep somatic muscular structures attached to the transverse process of the first lumbar vertebrae. The somatic and visceral referred pain is so similar that differentiation is impossible unless the back is closely examined for myalgic areas. Often, involvement of the structures about the lumbar joints may likewise be referred in the same manner. This pain is referred along the recurrent branch of the posterior sensory root just before the spinal nerve leaves the intervertebral foramen along the peripheral nerve distribution. So pain felt in the peripheral distribution of the first lumbar segment may arise from a pathological condition of the ureter, lumbar articulation, or from muscle supplied by the sensory branches of that nerve.

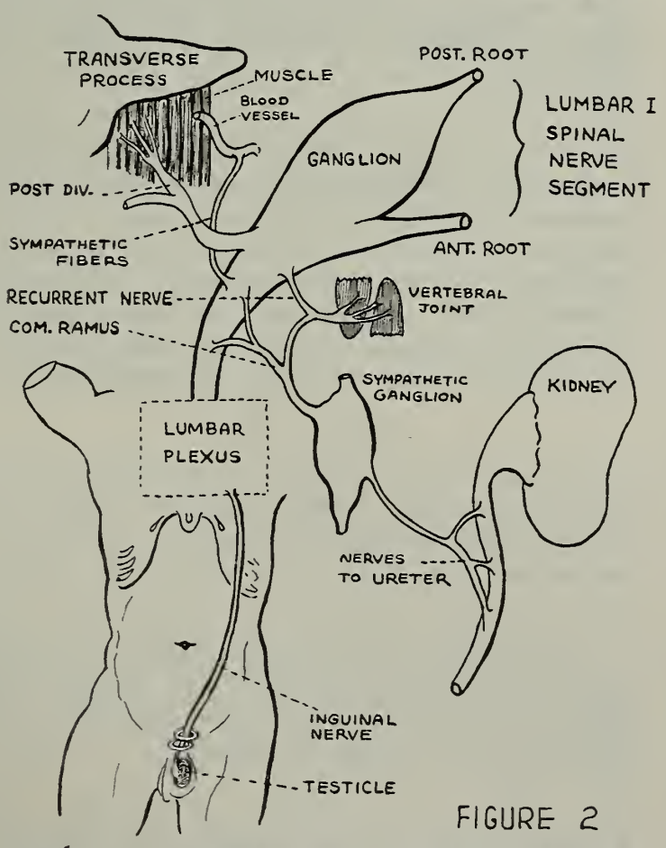


Figure 2. Modified schematic drawing of innervation of kidney, spinal joint, and paravertebral muscles and peripheral nerve distribution to inguinal region. (Modified from Quain's Anatomy).

Other examples could be cited but this will suffice to show the relationship of referred pain to involvement of structures supplied by a given spinal nerve.

The author is convinced that in the production of this back ailment, a reflex sympathetic system "circus" phenomenon is set up producing a vasomotor response in certain muscles at the myotendinous attachment.

Exactly what occurs in this region is not known as yet but localized muscle spasm is set up with stimulation of pain fibers producing a false localization of pain in the peripheral distribution of spinal nerves.

I feel that there is more evidence to support such a mechanism than the long established fibrositis theory. To describe this syndrome, I suggest the following name, "Myospastic Syndrome."

SUMMARY

An attempt has been made to classify cases of low back pain which fall into the class of fibrositis. This group has a very definite clinical history and physical findings.

Scientifically, insufficient evidence exists to warrant the acceptance of the presence of inflammatory changes in intramuscular fibrous tissue as an explanation of the palpable nodules found in these cases.

Briefly, evidence has been presented to show that this entire syndrome can be explained on a mechanism involving the sympathetic nervous system with its vasomotor effect, the localized muscle spasm with subsequent production of local and referred pain in a segmental distribution.

Whether the etiology be of a rheumatic, traumatic, or an infectious nature, a myalgic lesion develops from which secondary phenomena

originate. A reflex action is set up and all forms of therapy whether they be medical, mechanical, manipulative, or chemical tend to break up the reflex mechanism.

Many errors in diagnosis have resulted because the occurrence of this syndrome was not appreciated, leading to unnecessary surgery or medical treatment. Many cases diagnosed as sacro-iliac, lumbosacral strains or neuritis of the extremities are actually myospastic syndromes.

Stress is placed on more complete examination of the back. The more frequent locations of tender areas have been presented. Guarded manipulations of the back and the judicious use of procaine is recommended.

A better and more logical theory to explain the so-called fibrositis syndrome is offered.

CONCLUSION

1. A classification of patients falling into so-called fibrositic syndrome group is presented.
2. The presence of fibrositic involvement of muscle in these cases is not accepted by the author.
3. Typical locations of myalgic areas are mapped out.
4. A theory to explain the mechanism of the production of the fibrositic syndrome utilizing as a basis localized myospasm with referred pain mediated through the sympathetic nervous system is offered.
5. The term "Myospastic Syndrome" is suggested to replace the term "Fibrositic Syndrome."

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The physician must regard cough as a symptom and although relief should be afforded the patient while the cause of cough is investigated, merely suppressing cough with a narcotic often will prove harmful.—*Cough, Louis H. Clerf, M. D., The Mississippi Doctor, July, 1949.*

KEEPING UP WITH MEDICINE

• IF you are past 65 years of age the chances are 55 out of 100 that you will die of a cardiovascular disease.

* * *

• DESPITE the fact that all or nearly all of the cases of essential hypertension can be shown to have reduced renal blood flow, little kidney change is noted grossly or microscopically in a number of cases.

* * *

• YOU and you alone, have the ability to think the kind of thoughts that you want to think.

* * *

• ONE-HALF the peoples of this earth live on less than 2250 calories per day and the crude death rate among such people averaged, around 1930, thirty or more per 1000. Whereas only one-fifth of the peoples of this earth enjoyed average daily diet of 2875 calories, or more, their crude death rate in 1930 was as low as 12 per 1000.

* * *

• ONE objective of our educational program should be to develop the skills necessary to avoid accidents.

* * *

• A WORLD-WIDE fear is being whipped up which may well hypnotize our minds, making us passive and ready to surrender. This may well be mass application of the mental tortures that lead to submission, confession, and mental disintegration.

* * *

• IT is important that every asthmatic be on a regime of therapeutic exercises aimed at increasing expiration, relaxing the auxiliary muscles and stretching them as well as power-building of these same muscles. Abdominal breathing and increase of the diaphragmatic movements are the most important parts of this program. The same goes for emphysema.

* * *

• CARDIOVASCULAR diseases do not necessarily prevent a person from earning a living in a suitable job and enjoying himself in appropriate recreation.

* * *

• IN addition to the psychological and psychomatic pressures, we should also consider the psychosocial stresses and strains upon the total personality as a cause of DISease.

* * *

• DISTURBANCES in the mouth from improper diet have been described in cases of fat indigestion. These conditions are accompanied by bad breath and are cured by a change in diet.—J. F.

Cancer Mortality Falls

GEORGE M. WILCOXON, M. D.

THERE is an improvement in the cancer mortality rate in women. This is one of the most welcomed signs of the year. The fight against cancer in women is beginning to show dividends. We are beginning to reap the fruits of a persistent campaign of popular education and propaganda regarding cancer. It was rather repulsive to most physicians to read signs which suggested one out of five would die of cancer unless you gave to the cancer fund. Many physicians were definitely against the cancer write-ups in the various magazines, radio programs and the general propaganda about cancer. But there is not a single sincere physician who can raise an objection to the American Cancer Society's advertisement, "The Wonderful Story of the Stitch in Time that Saved Nine." This is a great advance, it raises morale, it elevates confidence. The factual dates and pictures of those cured of cancer has a stimulating effect. Since the better propaganda overbalances the objectionable, we are apparently over that growing stage of the campaign. Now we have a drop in the cancer mortality rate in women of approximately eleven per cent. This cannot be dismissed lightly as it means about eleven thousand of our women are going to be with us for a few more years.

In spite of the gains in cancer deaths the real fight against cancer is just beginning because about 100,000 women in the United States are expected to die from cancer this year. This death toll which is second only to heart disease is likely to rise as the number of older women in our country increases. Cancer in women leads heart disease in the 30 to 60 age groups and accounts for almost three out of ten deaths at these ages. However, it is to the women of this period of life that the greatest hope for the control of cancer exists today.

BEST RECORD

The death rate from cancer in women is at the lowest level on record. Every age group between 25 and 74 years has benefited by this decline. In Connecticut, women who had cancer and survived for at least five years increased from 25 per cent for those first treated in 1935 to 40 per cent for those first treated in 1941.

In contrast to the favorable situation at ages beyond 25 years the apparent death rate from cancer in girls and young women has been going up. The cancers at the early ages differ somewhat from the cancers at later ages, especially as to where they are found and the types, the squamous cell carcinoma of the cervix developing in the younger age groups while the adenocarcinoma of the fundus occurs in the older women.

Submitted October 5, 1949.

The Author

● Dr. Wilcoxon, Alliance, Ohio, is a graduate of University of Chicago, The School of Medicine, 1934; diplomate, National Board of Medical Examiners; member, American Congress of Obstetrics and Gynecology; chairman, Gynecological staff, City Hospital, Alliance; and head of Smear Laboratory, Carnegie Medical Building, Cleveland.

WOMEN ALERTED

There are a number of items which account for these encouraging trends. Women have become particularly responsive to the American Cancer Society campaign and have become more alert to the early danger signals of cancer. They are thus seeking medical attention earlier in the course of the disease, when the chances of cure are more favorable. For example, among new patients with suspected or proved cancer first seen in the examining clinic at Memorial Hospital in New York, there has been a marked decline in the frequency of delay after first symptoms. Patients who had delayed three months or more decreased from 62.3 per cent of the total in 1923-1938 to 42.8 per cent in 1946. This is a drop of 20 per cent in eight years.

Why are women seeking examinations for cancer more frequently than men? Many reasons might be advanced but two important reasons are outstanding. Women's magazines have given tremendous publicity to the value of early diagnosis in cancer and many women have club programs which encourage them to think about and discuss the cancer problem. Secondly, the newest and best test for cancer has been applied to women. The Papanicolaou test for cancer of the female genitalia has made tremendous strides in the diagnosing of early cancers. There are probably many reasons why women have been going to their doctors for examinations but the main thing is that they have been doing this very important thing and therefore they (the women themselves) have been most instrumental in lowering the cancer death rate in women.

DETECTION FOR WOMEN

In the Cleveland Cancer Detection Clinics in 1947, two and one-half times as many women as men voluntarily were examined. In 1948

there were even more women than in the previous year. For every man examined at the clinics there were 3.25 women. This is one of the real reasons why the cancer death rate in women is falling under the constant attack against one of mankind's greatest enemies. Women are becoming conscious of the fact that they can save their own lives by regular examinations. Cancer in women in the city of Cleveland is bound to drop because of the effectiveness of their system of Detection Clinics.

Education and understanding are knocking down the barriers to cancer. People are becoming unafraid to admit they have cancer. People are learning that they may be made well again if they can stop a cancer before it is too late for modern treatment to be effective. Finding cancer early by frequent examinations is the most effective means against cancer known to science today.

FREQUENT EXAMINATIONS

Every physician in the United States and Canada can have the means available to take the Papanicolaou test in his office. This test is very accurate in determining cancer in the genital tract of women. Every woman under forty years of age should have at least one test a year and those over forty years should have a test every six months. It takes an experienced reader to interpret the Papanicolaou test. There are enough readers and laboratories at the present time to take care of the present demand. By using this method it is now possible to discover cancer that is impossible to detect clinically by any other method. It is possible to discover a cancer that has not grown enough to give the patient a single symptom. It was unknown to discover this form of cancer before with the exception of when an organ had been removed for some other reason.

Because it is possible to use the Papanicolaou test to discover these cancers it will require an entirely new classification of cancers, not only nationally but internationally. At the recent American Medical Association meeting a new classification of uterine cancers was suggested.

LOWER RATE

Cancer Detection Clinics all over the country are helping to lower the cancer mortality rate. They are finding early cancers which have a high cure rate. In women, cancers of the breast and uterus alone constitute about two-fifths of the deaths from all malignant neoplasms. If cancers of other genital organs are added to cancers of the breast and uterus a total of 41 per cent of all cancers in women is reached. If one analyzes the cancer mortality in women between the ages of 35 and 44 years it is astonishing to find that 58.9 per cent of all the cancer deaths in women are from the cancers of the breast, uterus and other genital organs. This rate falls as the women become older as shown in Table I.

Table I

CANCER DEATHS IN WOMEN 1946-1947*

Primary Site	Total Years 1-74	Years 1-14	Years 15-24	Years 25-34	Years 35-44	Years 45-54	Years 55-64	Years 65-74
Digestive	38.4	3.5	11.0	18.4	21.5	30.4	39.7	49.5
Breast, Uterus Other Genital Organs	41.0	2.5	12.0	47.3	58.9	51.1	41.3	32.0
Respiratory System	3.6	1.3	3.7	3.3	2.9	3.1	4.1	3.8
Urinary Organs	3.1	7.8	1.0	1.1	1.6	2.6	3.2	3.8
Brain, Central Nervous System	1.6	16.5	9.4	6.1	2.5	1.7	1.4	.4
Bone	1.1	9.5	8.9	1.7	.9	.8	1.0	1.0
Leukemia, Aleukemia	3.0	46.8	24.1	6.9	3.9	2.5	2.0	1.7
Hodgkin's Disease	.9	1.7	12.6	6.3	1.3	.8	.6	.4
All Other Cancers	7.3	10.4	17.3	8.9	6.5	7.0	6.7	7.4

* Metropolitan Life Insurance Company, White Females.

It is interesting to note that digestive cancers increase as women become older. Physicians working in Cancer Detection Clinics should be especially well acquainted with cancer statistics—in fact, all physicians doing general examinations should know cancer statistics. If a physician is familiar with the first two lines in Table I he will have a firm grasp on 79.4 per cent of all cancer deaths in women. It would be well for Cancer Detection Clinics and physicians to have these statistics where they can refer to them during examinations. It is the cancers of these and other accessible sites which have accounted for the major part of the recent decline in cancer death rate among women. Since these cancers are most likely to be disclosed by the type of examination offered in the average Cancer Detection Center an improvement may be expected in the future. Detection Centers should strive to examine the women between the ages of 35 and 54 years as that is where the greatest improvement in cancer deaths can be made. As successful methods of Cancer Detection Centers are adopted by other medical facilities and by the private physicians in their own offices, the cancer death rate in women will drop accordingly.

SUMMARY

1. There is an improvement in the cancer mortality rate in women in our country.

2. The American Cancer Society deserves some of the credit for this successful advance in the cancer field.

3. The women of our country deserve the largest share of credit because they are presenting themselves for early examinations. A few years ago modesty prevailed on the part of the physician and women patients and women were reluctant to present themselves for physical examination.

4. Detection Centers are helping to lower the cancer mortality rate.

Hysterectomy: An Analysis of 225 Cases

JOHN F. MOHAN, M. D.

THIS paper is an analysis of 225 hysterectomies performed at the DeCourcy Clinic during the years of 1946, 1947 and 1948. It is written as a sequel to a report of 510 hysterectomies published in 1943 by Dr. Joseph L. DeCourcy. In this group there were 350 panhysterectomies, 140 supracervical hysterectomies, and 20 vaginal hysterectomies. There were two deaths in the series, both following the supracervical operation.

Our approach to the problem of hysterectomy has been to consider each case individually and to select that operative procedure which would seem best suited to the problem which that particular patient presents.

Such factors as age, the general physical condition of the patient, and the type and extent of pathology are taken into consideration in selecting an operative plan.

Patients with fundal or adnexal pathology complicated by infected, lacerated, and eroded cervices are generally treated with the total hysterectomy. In all operative cases of ovarian and fundal carcinoma, panhysterectomy has also been the operation of choice.

The supracervical hysterectomy is employed in cases of extensive adnexal inflammatory disease, endometriosis, and in certain previously operated cases where the pelvic scarring and adhesions render the more radical operation an increased risk to the patient. This technique is also employed in patients who are poor surgical risks because of hemorrhage or other complications, and in those cases with fibroid tumors so placed as to make access to the parametrial areas or bladder reflection difficult, and so increase the probability of ureteral or bladder damage. When dealing with very large fibroids the supravaginal operation is also elected.

In this clinic the vaginal hysterectomy is confined to those cases with extensive degrees of uterine prolapse. We believe that without extensive procidentia the vaginal operation becomes a very unsurgical procedure. The operation is performed more by sense of touch than by actual sight, and hemostasis becomes difficult and hazardous. In addition the possibility of bladder, ureteral and intestinal damage is greatly increased. The vaginal approach also lends itself poorly to dealing with such adnexal complications as may be encountered.

INCIDENCE

Table I shows the incidence of the different types of hysterectomy in our present series of 225 cases along with their occurrence as to parity, race, and age grouping.

The incidence of supracervical hysterectomy as seen in the above table, is somewhat higher in the Negro race than in the white race. This is due principally to the predilection of colored people to the development of very large fibroids and extensive cases of pelvic inflammatory disease.

The 36.4 per cent incidence of supracervical hysterectomy as compared to a 9 per cent incidence of total hysterectomy among the nulliparous patients was due to the lower rate of cervical pathology among this group. The multiparous women, having borne children, are more prone to extensive degrees of cervical infection and laceration and are generally treated by the total operation.

Table I

		Pan-hysterectomy 75		Supracervical hysterectomy 129		Vaginal hysterectomy 21	
		No.	%	No.	%	No.	%
COLOR:							
	White	67	89.3%	105	81.4%	20	95.2%
	Negro	8	10.7%	24	18.6%	1	4.8%
PARITY:							
	Nullipara	9	12 %	47	36.4%	1	4.8%
	Multipara	66	88 %	82	63.6%	20	95.2%
AGE IN DECADES:							
	20	4	5.3%	13	10 %		
	30	27	36 %	50	38.8%		
	40	35	46.6%	52	40.3%	3	14.3%
	50	8	10.7%	8	6.2%	11	52.4%
	60			6	4.7%	6	28.6%
	70	1	1.3%			1	4.8%

The highest incidence of the abdominal hysterectomies was found to be in the third and fourth decades of life. This was to be expected as it is at this time that pelvic lesions begin to show the more severe symptoms. Uterine fibroids have reached their greatest development, the incidence of abnormal uterine bleeding is on the increase, and pelvic carcinoma is

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more frequent. These factors, combined with the natural reluctance of both the patient and the physician to operative intervention at an earlier age, would lead one to expect a greater incidence of hysterectomy in those years approaching the menopause.

The vaginal hysterectomy was found to be more common in the fifth and sixth decades of life with 52.4 per cent occurring in the fifth decade. This was to be expected as all cases of vaginal hysterectomy were limited to patients with extensive degrees of procidentia, and the more extensive uterine prolapse is more commonly found in this age group.

There was one incidence of third degree procidentia in a member of the Negro race. This case is singled out for comment because we believe that complete uterine prolapse is uncommon among colored women.

DIAGNOSES

Table II shows the occurrence of the various diagnoses in this series. This is an over-all picture, some of the patients being listed as often as two or three times depending on the pathological findings.

Table II

Uterine Fibroid	129
Chronic Pelvic Inflammatory Disease	91
Chronic Cervicitis	67
Ovarian Tumor	19
Endometrial Polyp	13
Endometriosis	16
Prolapse	28
Adenomyosis	10
Carcinoma Uterine Fundus	6
Carcinoma of Cervix	4
Postoperative Adhesions	6
Tuberculous Salpingo-oophoritis	1
Ovarian Carcinoma	2

Five of the cases of carcinoma of the fundus were first treated with radium and followed in six weeks by panhysterectomy. Treatment was completed by deep X-ray therapy. The sixth patient was treated by panhysterectomy and deep therapy.

One of the cases of carcinoma of the cervix was missed prior to operation and was discovered following supracervical hysterectomy for uterine fibroids. The second case fell into group I—pathologically and clinically, and was treated by total hysterectomy. The other two cases of epidermoid carcinoma of the cervix were more extensive and were first treated by radium and deep X-ray therapy, and followed by panhysterectomy.

This is contrary to our practice in this clinic where carcinoma of the cervix is usually treated by radium and deep X-ray.

There were 16 cases of endometriosis by clinical diagnosis at operation. In some of the cases the diagnosis was not substantiated by the pathologist. This is frequently the case in endometriosis as the microscopic diagnosis is dependent on the pathologist receiving a section containing the typical endometrial glands.

ADDITIONAL OPERATIVE PROCEDURES

Table III shows the additional operative procedures performed in conjunction with those hysterectomies.

Table III

Bilateral salpingo-oophorectomy	145
Appendectomy	102
Perineorrhaphy	56
D & C	16
Anterior Wall Repair	20
Cauterization of Cervix	24
Lt. salpingo-oophorectomy	12
Rt. salpingo-oophorectomy	10
Bilateral salpingectomy—rt. oophorectomy	5
Small bowel resection	1
Bilateral oophorectomy—rt. salpingectomy	1

The large number of salpingo-oophorectomies is due to the high incidence of pelvic inflammatory disease and to the fact that the largest number of the abdominal hysterectomies occurred in the waning years of reproductive life. It has been our policy to be less conservative with patients past the age of 35 with a view to limiting the necessity of repeat pelvic operations, which in the past have been so common, particularly following conservative procedures in the presence of pelvic inflammatory disease.

In this small series of 225 cases, forty-five of the patients had had previous pelvic operations. In addition, in the menopausal group, the removal of questionable adnexae may be considered prophylaxis against the development of ovarian malignancy.

It is our custom on all laparotomies to perform incidental appendectomies on all cases in which there is no contraindication, and in which the condition of the patient permits.

Perineorrhaphy was performed in all cases in which it was indicated. This operation is necessary in many cases requiring hysterectomy, particularly in multipara, in order to obtain the best functional and clinical results.

Cauterization of the cervix was done in all cases of supracervical hysterectomy in which there was any evidence of cervical infection.

OPERATIVE COMPLICATIONS

Table IV shows the complications that occurred during the operative procedures.

Table IV

Perforation of the uterus at D & C	2
Resection of Small Bowel	1
Repair of Injury to Small Bowel	2
Perforation of the Bladder	1
Perforation of the Sigmoid Colon	1
Vesico Vaginal Fistula	1

There were two cases in which perforation of the uterus occurred during a D & C. One case was a patient with a fundal carcinoma, and the other patient was an elderly woman

with an atrophic uterus. Both perforations were followed by hysterectomies.

There were three cases of injury to the small bowel. In one case the injury was extensive enough to require resection of a portion of the bowel. The other two cases responded to simple suturing to repair the laceration.

There were two cases of injury to the bladder. One was a perforation during a supracervical hysterectomy in which the incision in the bladder was closed by an inverting Connell suture and an indwelling catheter was inserted. The patient recovered without incident. The other case was a vesico-vaginal fistula following total hysterectomy. The fistula was successfully repaired from above, six weeks following the hysterectomy. It was apparently the result of including a portion of the bladder in the running lock suture used to close the vaginal vault.

The perforation of the sigmoid was not noted at operation and a fecal fistula developed on the third postoperative day. This fistula closed spontaneously in ten days. There were no complications including injury to the ureter in this series of cases.

POSTOPERATIVE COMPLICATIONS

In Table V are shown the postoperative complications.

Table V

Paralytic ileus	8
Pelvic Peritonitis	3
Vaginal Hemorrhage	3
Pneumonia	4
Atelectasis	1
Toxic Psychosis	1
Fecal Fistula	1

Because of the fact that we have limited the more extensive lesions and poorer operative risks to the supracervical operation, the greater percentage of postoperative complications and all of the postoperative deaths in both of our series have been following the supracervical procedure. This has been particularly notable in the incidence of paralytic ileus. The more frequent occurrence of ileus following supracervical hysterectomy was due to the greater amount of bowel handling necessitated by the freeing of the many and dense adhesions of the more severe cases of pelvic inflammatory disease which were generally treated by this technique.

There were three cases of postoperative vaginal hemorrhage. One followed panhysterectomy and the other two followed the supracervical operation. The hemorrhage following the panhysterectomy was due to bleeding from the vaginal cuff. In the two cases done by the supracervical technique, the bleeding in one case followed cauterization of the cervix and in the other the bleeding was from a perineorrhaphy. The bleeding in all cases was controlled by the use of a vaginal pack.

MORBIDITY

The figures in Table VI show the morbidity average in this series for the three types of hysterectomy. The first day postoperative was not included in the figures.

Table VI

	Days Over 100.4°	Days Over 99.4°
Supracervical hysterectomy	1.06	2.55
Panhysterectomy	1.56	2.34
Vaginal hysterectomy	3.4	3.6

These figures are probably distorted due to the frequent use of penicillin and sulfa drugs. In some of the more severe cases of pelvic inflammatory disease and in cases complicated by extensive adhesions, sulfonilamide powder was placed in the abdomen before closing. In these cases, and in others in which we feared infection, prophylactic penicillin and sulfadiazine were used postoperatively. If it were not for the use of these drugs the morbidity figures in this series would have been higher.

It will be noticed that the figures for the supracervical and panhysterectomy parallel each other very closely. This is contrary to expectations because, as noted previously, the supravaginal technique was used more widely in the cases presenting the more extensive pathology and in the poorer operative risks. It would seem logical to have these patients run the higher morbidity. In most of the reports in the literature the morbidity for the supravaginal operation exceeds the morbidity for the panhysterectomy. This finding may be due, again, to our use of prophylactic antibiotics.

The morbidity figures for the vaginal operation are considerably higher than for the abdominal hysterectomies. This finding concurs with most other reports.

There was one postoperative death in this series of 225 hysterectomies. This death occurred in a patient who had a supracervical hysterectomy for bilateral ovarian dermoid tumors. The patient never recovered consciousness following the anesthetic, and she died on the second postoperative day. Autopsy examination showed thrombosis of the middle cerebral artery due to a fat embolus.

In the previous series of 510 cases reported in 1943 there were two postoperative deaths, both following the supracervical operation. The present series makes a total of 735 hysterectomies with three deaths or a mortality rate of .41 per cent.

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A Report on Postgraduate Work in Rotunda Hospital, Dublin, Ireland

F. GRAHAM FALLON, M.D.

THE Rotunda Hospital of Dublin, Ireland, is the oldest maternity hospital in the world, having been founded in 1743. The hospital at present contains 175 beds—113 maternity, 32 gynecology, and 30 in the Infant Department. The hospital supervises 6,000 deliveries a year—4,000 in the hospital and 2,000 in the district.

Besides the usual personnel connected with every hospital, there is the Lay Superintendent and the Medical Superintendent, who is respectfully called the Master. The present Master, O'Donel Browne, is King's Professor of Midwifery in Dublin University. Associated with him are two assistant masters and the equivalent of three residents. The Rotunda Hospital is affiliated with Dublin University, better known as Trinity College.

Postgraduate work at the Rotunda provides facilities for delivery of normal and abnormal cases under supervision. It provides opportunity to assist at and perform gynecological and obstetrical surgery; to receive clinical instruction in the examination and diagnosis of gynecological cases; to attend lectures in gynecology, obstetrics, gynecological pathology, and pediatrics; and to attend antenatal and postnatal clinics. This program of work is spread out over the entire week, with a routine schedule for each day. Some of the lecture work is given by staff men of the hospital, by previous masters or assistant masters, a master being appointed for a single term of seven years.

The Antenatal Clinic is held every day except Saturday and Sunday. Approximately sixty to eighty expectant mothers are seen each day. Part of the work of the postgraduate student is taking blood pressure in the Antenatal Clinic. Here it was not unusual to see women under 40 years of age with eight to fourteen children. None of the patients showed a blood pressure over 140. From the antenatal group, any interesting or abnormal cases are screened out; and following the Antenatal Clinic, these selected cases are reviewed by the Master or one of his assistants.

The hospital is not operated for profit, although some private cases are cared for here. An attempt is made to procure part pay from some patients; but the large majority are poor patients unable to pay.

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There is considerable poverty in Dublin, but no starvation. During my stay there, I had an excellent opportunity to observe the native life, as it is necessary for a Postgraduate to do some work in the District. I paid particular attention to the children in the streets and in the homes, and saw few undernourished or underfed children. They were not thin and scrawny. On the contrary, they were fat, well nourished and developed, although poorly clad. The hospital was located near the poorer section of the city, which may have accounted for much of the poverty I personally saw.

ANESTHESIA AND ANALGESIA

I saw no spinal anesthesia used at all, but did not learn why it was not popular. For analgesia, pethedeine is used. Here it is known as demerol. This is supplemented with trilene and a gas mask. The patient breathes in her own analgesia. For delivery, drop ether or nitrous oxide and ether is used. Intravenous sodium pentothal has been used for a few cases, which were calculated to be brief. It was stated that if the delivery would not take more than eight minutes, sodium pentothal was thought to be safe. Of course, the obvious argument against sodium pentothal is that one cannot always foretell the length of the second stage of labor.

About their surgical technique, I think the story can be summarized in these words: They are not as meticulous as we are, however, their morbidity and mortaliy rates and the incidence of infection are no greater.

I was impressed by the excellent obstetrical judgment and the methods by which they arrived at their conclusions in evaluating a borderline case. After due consideration of the history of the case, X-ray pelvimetry is done. Then the patient is brought to the delivery room, prepared and anesthetized with intravenous sodium

pentothal, and a thorough vaginal examination is made. The final decision for the disposition of the case is then made. High forceps are rare. If it is determined that a case can deliver vaginally, the patient is allowed to labor until the head is brought down where low forceps will deliver the baby, unless there is definite indication for previous interference.

TREATMENT OF ECLAMPSIA

A patient is admitted having convulsions. She is given morphine sulphate grains ¼, 500 cc twenty per cent glucose and one gram sodium pentothal in 500 cc distilled water. She may be given three pints a day of this sodium pentothal solution. If the blood pressure goes down and albumin in the urine clears up, treatment is expectant. If, however, after two to three days' treatment, the blood pressure again rises, they do a section.

Low Caesarian sections are definitely preferred to the classical sections because they have fewer ruptured uteri in subsequent pregnancies.

Of course, as you might guess, breast feeding is very popular and is very much encouraged.

I suppose you will be amused and think it terribly obsolete when I tell you that all well babies are kept in a cradle, which hangs at the foot of the mother's bed; and in the Coombs Hospital, in Dublin, the mother keeps the baby in the bed with herself. Babies are bathed by the nurses at the side of the mother's bed.

They have no impetigo, and use neither penicillin intramuscular nor penicillin ointment prophylactically. I was particularly interested in this point. They attribute the absence of impetigo to their care of the newborn. Immediately after birth, the doctor or a sterile nurse ties the cord and expresses any residual blood out of the cord. The cord is powdered with boric acid powder and starch, wrapped in sterile gauze, and the binder is sewed on the baby. The baby is not bathed until the sixth day and the vernix is allowed to remain on the baby.

CARE OF PREMATURE BABIES

All premature babies are given 300,000 units of intramuscular vitamin D, ¼ grain thyroid the first day and 1/10 grain daily until the heat regulatory system of the body is normal. They are given vitamin A concentrated, five drops daily and twenty-five milligrams vitamin C daily. One-half strength Ringer's solution ½ dram for every two pounds of weight every two hours. After the baby starts to feed he is given one-half breast milk and one-half five per cent glucose solution.

FOR CEREBRAL BABIES

For babies who have had long labor with ruptured membranes, oxygen is given together with 25,000 units of penicillin every three hours until one million units have been given and 1/10 grain streptomycin every six hours is administered.

For expectant mothers with iron deficiency anemia, ferrivenin is given intravenously, and contains saccharated oxide of iron. Each ampoule contains 100 milligrams of elementol iron. The results are very gratifying.

Bisoxyl is used for treatment of leutic mothers and babies. It contains a very high percentage of bismuth in the form of its oxychloride. It is absorbed rapidly and is practically painless. One of the men on the staff is using it in his private practice for the treatment of Rh negative mothers who have lost one or more children, with suprising results. The rationale of this treatment is that it draws the antibodies to the site of the injection.

Except in the northern part of Ireland, the practice of medicine is free enterprise.

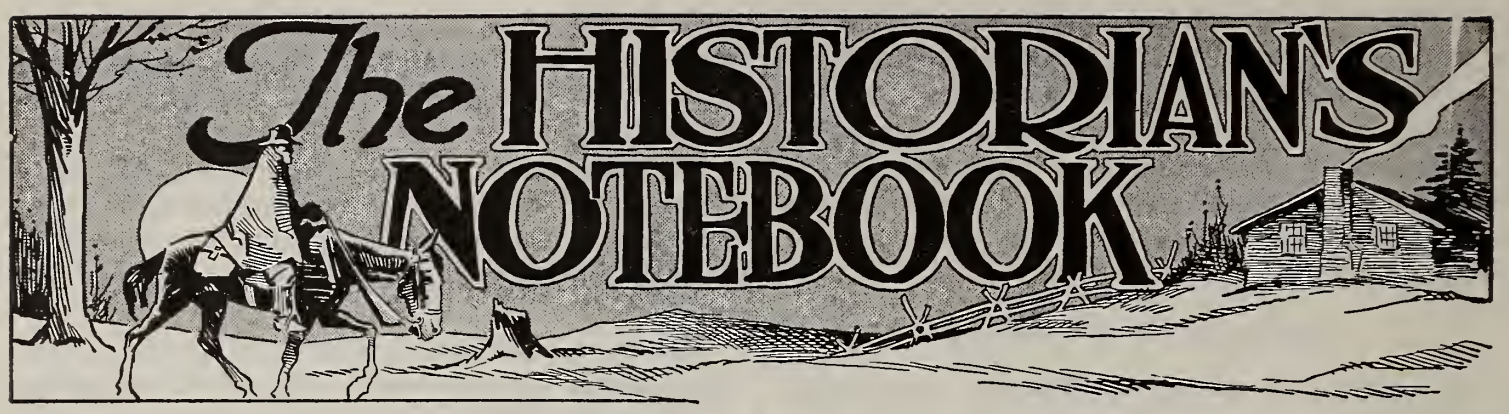
The Irish people have made great progress since gaining their freedom from England, and you may expect greater progress in the next ten years.

Value of Routine Proctoscopy

It has been estimated that from 60 to 90 per cent of colonic and rectal polyps will undergo malignant change. Assuming these estimates to be reliable, it is obvious that cases of lower bowel cancer are prevented, and more could be prevented by the proper removal of these polyps when found. As 50 to 70 per cent of all colonic polyps occur within reach of the 25 cm. proctoscope, and as about 40 per cent of patients with these lesions in this series were without symptoms, the value of the routine use of the proctoscope is obvious. In each 100 individuals examined about three cases of preventable cancer will have been found.—Dan B. Greer, M. D.; Med. Annals of The District of Columbia, Vol. XIX, No. 3, March, 1950.

Treatment of Brucellosis

Several facts should temper one's expectations of both aureomycin and chloromycetin. Their *in vitro* effects are primarily bacteriostatic instead of bactericidal, and they are quite inferior to the effects of combined streptomycin and sulfadiazine. In well-controlled experiments on laboratory animals, the effectiveness of both aureomycin and chloromycetin was less than that of combined streptomycin-sulfadiazine. In the treatment of naturally infected cows with large doses of aureomycin, the excretion of brucella in the milk recurred promptly after cessation of treatment in every instance.—C. Wesley Eisele, M. D., Chicago; Wisconsin Med. Journal, Vol. 49—No. 3 March, 1950.



Culture Is Based on History; and History Is Based Upon the Written Word

PART I

JONATHAN FORMAN, M. D.

IN recent months there have appeared quite a goodly number of books on the history of medicine. As is to be expected these vary from the dry scholarly volumes of the professional historians to the lively stories and autobiographies of those more popular medical writers who like to look into the past.

All of this is to the good. The more that we know about the past, the more wisely can we face the uncertainties of the future. The more that we physicians realize how we, of the healing arts, have always been integrated into the social structure of every period in the history of the race, the less apt we are to feel that we are set apart for change. So we shall realize that we shall not be nationalized as a profession unless insurance companies, banks and the legal profession suffer a like fate. We shall, therefore, oppose not only "State medicine" but more directly socialism. We shall realize that we are in the era of state capitalism, approximately the situation in the Fascist states and move now into state socialism which calls for a dictator from the ruling classes or from the laboring classes. This is of real significance to us. We will try, if we understand history, to rally all our people against socialism, not because it might harm us or even destroy our form of government but because Karl Marx is the anti-Christ. There are confused minds like Norman Thomas who heartily believe that we can be two opposite things at once and do the impossible; that is, be a Christian and a Socialist. This is a disillusion. Christianity and Socialism cannot be mixed. The basic idea of the Judeo-Christian concept of why we are here is the dignity of Man and the importance of the individual human being and his right to discharge his duty in the development of his own character and soul.

The Author

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ANTIQUITY

One of the interesting of the more scholarly studies in the field of the history of medicine is Robert O. Steur's **Aetiological Principle of Pyaemia in Ancient Egyptian Medicine** ($1.50, *Johns Hopkins University Press, Baltimore).* The study of the word "whdw" has brought forward evidence of the Egyptian outlook with regard to mummification and the etiology of suppurative conditions, to explain how the concept of "septicemia" was based upon a general principle of physical destruction ("whdw") applicable to the living and, after physical death, to the corpse. Thus the Egyptians attributed to "whdw" a wider meaning which transcends the concept of a strictly aetiological term.

Another supplement to the Bulletin of the

history of medicine is a translation of Paracelsus **Volumen Medicinae Paramirum** ($1.75, *Johns Hopkins Press, Baltimore, Md.)*. It will repay us all to study the life and works of this great man who to most of us is only a character in the ritual of the medical fraternity or a name we find occasionally in our books. If we are to be able to evaluate the anti-intellectualism of our time—and God knows this needs to be encouraged as higher education becomes big business—then we should know this fearless man who smashed the icons of the ancients, particularly Galen, while he extolled the ethical calling of the physician and described with clarity "the huge pattern on which both God and the physician weave and Nature provides the loom and other essentials."

We should be able to see this pattern as it runs through the healing Arts from the beginning. Benjamin Lee Gordon helps us to go back to the beginning with his new book **Medicine Throughout Antiquity** ($6.00, *F. A. Davis Co., Philadelphia)*. He gives us an excellent resumé of medicine, as it was conceived, developed and practiced by the various peoples of antiquity. Dr. Gordon has succeeded admirably in his attempt to collect and systematize facts and so to give us in a single volume a comprehensive account of the essential aspects of ancient medicine. You might do medicine a lot of good by telling some clubs in your area about some of the contents. Have you ever thought how efficient a dose of propaganda for the Christian ideology as opposed to Marxism could be woven into a discussion of ancient medicine?

Another book on the history of medicine is not an essential contribution to curative medicine. Nevertheless it can be a great contribution to the culture of our people for the basis of all culture is a knowledge of history. Bernard J. Ficarra, M. D., has written eight delightful essays, **Essays on Historical Medicine,** *(Froben Press, New York City)*. The author has blended ancient facts into a new perspective. He offers the past and present together in sharp focus. "American Pioneer Surgeons; Amputation and Prosthesis Throughout the Centuries; Famous Cripples; Surgical References in Shakespeare; Blood Transfusion; Walter Reed at King's County; An Historical View of Pathology; Famous Autopsies" are the titles of the respective essays.

THE STUDY OF MEDICINE

The story of medicine is always a fascinating one. One that every physician should do something about. It is my contention that if each of us would take off time and prepare a 45-minute paper on how human beings have developed the art of caring for their sick we could do this in such a way that people would come to realize that medicine is an Art and never will be a science. Then our talk about physician-patient relation would have a new meaning for the public. They would understand how the nationalization of medical care would defeat its own purpose by destroying our professional status and making of us just simple technicians.

In **The Story of Medicine,** by Joseph Garland, M.D., ($2.75, *Houghton Mifflin Co., Boston)*, the author has written a book on a level of readability that gives it wide appeal and one from which you can readily rework your paper for P. T. A.'s, Women's Clubs and Service Luncheon Clubs in your area. Then, too, if you would like to refresh and brighten up a bit your own knowledge of how your day's work came to be what it is, read Garland's 239 pages.

The Greek Doctors, by John William Charles Wand, Bishop of London, England; ($1.05, *The Faeth Press, Ltd., London; Morehouse-Gorham Co., New York)*, was thought to have to do with ancient medicine. The office was not familiar with the author or his previous book on Latin Doctors, or we would have known these were the doctors of the eastern and western church respectively. They were written to teach the rather unusual principle in church administration that a bishop should be the leader of his people.

IN COLONIAL DAYS

Aesculapius Comes to the Colonies, by Maurice Bear Gordon, M. D., ($10.00, *Ventnor Publishers, Inc., Ventnor, N. J.)* is the study of the early days of medicine in the thirteen original colonies, fittingly enough by the son of the author of **Medicine Throughout Antiquity** described above. It is a frank book as such a book should be. The author glamorizes none of our forefathers. Medicine in America was not born with a silver spoon in its mouth. It has come up the hard way. We, its servants, have been men of "guts" but bigoted and uncultured, living intensely and hating with passion. Always, as the author brings out, that five per cent of "S. O. B.'s" active in our midst bringing discredit to our profession. The corruption and inefficiency in the medical department during the Revolutionary days under Shippen remains one of the blots, reminiscent of the canned beef of the Spanish American War. I would urge that you read this book and put it in your library. It will make both realists and patriots of you and yours.

In 1818 **The First Medical College in Vermont** ($4.50, *Vermont Historical Society, Montpelier, Vt.)*, opened its doors at Castleton. Dr. Frederick Clayton Waite, emeritus professor of Histology at Western Reserve University gives us the complete history of its 44 years. Medical colleges in small towns were a prominent feature of American medical education in the nineteenth

century. As the cities grew opinion became divided as to the worth of these country schools. Most of them lost out in competition with the urban medical schools. Dr. Waite is known to most Ohio physicians for his vigor as a teacher and to the medical world as a whole for his research into the history of medicine in the United States. For over 30 years he has been interested in "country medical" schools and has given most of his spare time and vacations to his researches about them. No one else has begun to accumulate so much material about them as he. He wrote the story of The Medical Department of Willoughby University of Lake Erie, in 1934, for the centennial volume of the medical college of the Ohio State University. Then, A History of the Medical School of the Western University, in 1945; The Vermont Historical Society published his History of the Woodstock School, and now the Castleton School. Here he has given us the story in intimate detail of the activities of a prosperous and comparatively long-lived country medical college as a basis of understanding the operation and many difficulties encountered by an institution of such type. It was the rural people of the east that settled our midwest. Hence our early physicians here in Ohio were largely of rural origin and those that held M. D. degrees for the most part received their formal education in these eastern country schools. The author has given us much information about similar institutions as well as a discussion of most of the conditions that applied to all country medical colleges.

PHARMACY

Dedicated to the memory of Johann Wolfgang von Goethe, Baron of the German empire, highest executive of the Grand Duchy of Saxon Weimar and one of the greatest poets of all time as well as uncrowned king of the intellectual world of his day, is a book written by George Urdang, Ph. G., D. Sc. Nat., Sc. D., and published by the *American Institute of History of Pharmacy* entitled **Goethe and Pharmacy** ($2.50 *Madison, Wis.)*. Pharmacy seems to have given Goethe the fundamental concept of order and the principle of system. Furthermore pharmacy gave to her men achievements and information which he cherished and collected. A delightful essay which I am sure you will enjoy and a nice Christmas present for your favorite druggists.

Then there is another book which most of us physicians would do well to read. It is **Pharmacy Forward**, by Frederick John Wulling, Dean of the College of Pharmacy of University of Minnesota, 1892-1936; ($3.00 *Emmerson G. Wulling, LaCrosse, Wis.)*. This book consists of "selections mostly not published before" from the diary, autobiography, speeches and reports, significant of a lifetime effort in the profession of pharmacy. From the age of 17 when the boy was apprenticed to a pharmacist until two months before his 82nd birthday when he closed his busy, vigorous life, pharmacy was central in his thoughts and activities. In view of the efforts of our officers and those of the Ohio State Pharmaceutical Association to understand each other better we physicians will do well to catch the fire that burned in this great soul and his ideals of standards, organizations, records, and research.

A Century of Medicine in Jacksonville and Duval County, Florida, ($3.50 *University of Florida Press, Gainesville, Fla.)*, by Webster Merritt tells the story of its title. It is more of a compilation of source material and biographical sketches than an interpretation of the history of north Florida as influenced by the medical profession.

The Bellevue Story.—Probably no American hospital presents more drama, despair, and miracles involving names. Page Cooper begins his version of **The Bellevue Story** ($3.00, *Thomas Y. Crowell Co., New York)* by reminding us that Stephen Foster died there alone and unrecognized with a half-written lyric pencilled on a scrap of envelope, and finishes by describing the bright new $15,000,000.00 mask that is being built for the spirit that is the real Bellevue. A delightful book that will make the visit of any one of us to New York the richer, if we have read it first.

Speaking of hospitals and the medical schools they have created, Bertram M. Bernheim, M. D., has written **The Story of the Johns Hopkins** ($3.50, *Whittlesey House, McGraw-Hill Book Co., New York City)*. It tells how four great doctors created a great medical school around their hospital. It is a human story told in an interesting fashion. It is the story of a great experiment in medical education. The author came to Hopkins in 1901 and has been with the institution for nearly 50 years as boy-man-student-teacher.

This then is not a dry recital of Hopkins' accomplishments. It is a picture that gives you the feel, the color, and the spirit of the institution. The author has presented likenesses of the chief actors in the drama. The lesson for you and me in all of this is that culture based on a knowledge of history, a refinement of feeling based upon culture, and an appreciation of the finer things of life based upon all of these, made it possible for its staff to serve humanity better. If medicine is to be saved as a profession in this mechanical age; if we, as physicians, are to master the Machine, we must instill into our hearts and into the souls of our young men the culture, refinement, and appreciation that comes from a knowledge of history.

(To be Concluded in July Issue)

Proceedings of The Council . . .

Important Matters Acted Upon at Sessions Held in Columbus, April 22-23; Statements of Policy on Numerous Questions Adopted; Committees Report

MEETINGS of The Council of the Ohio State Medical Association were held at the State Headquarter's Office, Columbus, on Saturday, April 22, and Sunday, April 23, 1950. All members of The Council, with the exception of Dr. J. Craig Bowman, were in attendance. Others attending were: Dr. Forman, editor of *The Journal*; Dr. Sherburne, an A. M. A. Delegate; Dr. David Chambers, Cleveland, Mr. John Lansdale, Jr., Cleveland attorney; Mr. Wayne E. Stichter, Toledo, legal counsel of the Ohio State Medical Association; Mr. Charles H. Coghlan, executive vice-president of Ohio Medical Indemnity, Inc., and Secretaries Nelson, Saville and Page, and Mr. Moore, news editor of *The Journal*.

On **motion** duly made, seconded and unanimously **carried**, the minutes of the last meeting of The Council held on Dec. 18, 1949, were approved.

MEMBERSHIP QUESTIONS

The Executive Secretary reported on membership statistics as follows: Total paid membership as of April 21, 1950, 7,221, compared to a total membership of 7,479 as of Dec. 31, 1949.

The Council authorized the collection of annual dues from new members on a pro-rated basis for the third and fourth quarters of 1950 as follows: **New members** affiliating in the third quarter of the year, $10.00; **new members** affiliating during the fourth quarter of the year, $7.00.

Communications from several members of the Association, now employed by the Veterans Administration and stationed in other states, expressing a desire to continue membership in the Ohio State Medical Association, were read and discussed. On **motion** duly made, seconded and unanimously **carried**, The Council instructed the Executive Secretary to accept membership dues from such members providing they are not eligible to become active members of the State Medical Society in the state in which they are now located and providing their continuation of membership has the approval of the appropriate county medical society in Ohio through which State Association dues shall be collected in the customary manner.

The Executive Secretary reported that 412 Fifty-Year emblems and certificates had been prepared and distributed for presentation to eligible physicians. A poll of members of The Council revealed that the great majority of the emblems and certificates have been presented. Ceremonies were scheduled by some of the societies during the month of May.

A. M. A. DUES

Follow-up procedure with respect to collection of 1950 A. M. A. membership dues was discussed. The Executive Secretary reported that as of April 19, 1950, 4,305 members of the State Association had paid 1950 A. M. A. membership dues, representing approximately 60 per cent of the paid-up membership of the State Association as of that date. On **motion** duly made, seconded and unanimously **carried**, The Council recommended that a communication be sent to all members of the Association who have not paid A. M. A. dues over the signature of the incoming president, Dr. Swartz. It was suggested that the letter should point out the reasons why a physician should belong to the American Medical Association. It was recommended, also, that a communication be sent to the secretary of each county medical society with a list of physicians who have not paid A. M. A. dues, suggesting that the local secretary make personal contact, if possible, with such physicians and urge them to send in their A. M. A. membership dues to the Columbus Office for forwarding to the Chicago Office of the A. M. A.

A letter from Dr. George F. Lull, secretary and general manager of the American Medical Association, asking for information regarding the cost incurred by state medical societies in collecting A. M. A. 1950 dues, was read and discussed. On **motion** duly made, seconded and unanimously **carried**, The Council instructed the Executive Secretary to provide Dr. Lull with this information.

CAN'T WAIVE DUES

A number of communications from physicians requesting exemption from payment of A. M. A. membership dues because of age, retirement, financial hardship, etc., were read and discussed. The Council expressed the opinion that no member of the Ohio State Medical Association would be eligible to apply for waiver of A. M. A. dues inasmuch as the Constitution and By-Laws of the Ohio State Medical Association provide for but one class of members, namely, active, dues-paying members and do not contain a provision for the waiver of dues in hardship cases. It was pointed out that the A. M. A. does not waive dues unless the State Association and the local medical society to which a man belongs

waive local and state dues. It was the sense of The Council that no change in the Constitution and By-Laws of the State Association should be recommended at this time.

A communication from a member recommending that The Council go on record as favoring and instructing Ohio's delegates to the House of Delegates of the A. M. A. to present a resolution to the effect that all members of the A. M. A. who paid the 1949 $25.00 assessment shall be given full credit for 1950 membership dues without the payment of an additional $25.00, was considered. The Council by **unanimous vote** expressed itself as not favoring the recommendation.

The annual audit of the books of the State Association and *The Journal* for the calendar year 1949, made by a firm of certified public accountants, was presented to The Council for review and discussion. On **motion** duly made, seconded and unanimously **carried**, the report of the accountants was approved and ordered filed.

AMENDMENTS APPROVED

An amendment to the Constitution and By-Laws of the Darke County Medical Society, adopted at a regular meeting of that society January 17, 1950, was presented for review by The Council. On **motion** duly made, seconded and unanimously **carried**, such amendment was approved.

An amendment to the Constitution and By-Laws of the Stark County Medical Society, adopted by that society at a meeting on February 9, 1950, was read and discussed. On **motion** duly made, seconded and unanimously **carried**, such amendment was approved. However, in the same action The Council instructed the Executive Secretary to point out to the Stark County Medical Society that physicians becoming associate members of that society under the amended section, with the exception of interns and residents and those who have retired from active practice, would not be exempted from active membership in the Ohio State Medical Association and would be required to pay current State Association dues, even though they might be exempted from the payment of local dues by the Stark County Medical Society by action of The Council of that society. Chapter I, Section 5, of the By-Laws of the Ohio State Medical Association was cited as the basis for the foregoing interpretation and opinion.

The Council authorized the reissuance of the charter of the Fairfield County Medical Society to replace the charter of that society which had been lost, and authorized the Executive Secretary to present this action to the House of Delegates at the 1950 Annual Meeting for ratification as required by the Constitution and By-Laws.

ANNUAL MEETING PLANS

The Executive Secretary reviewed all arrangements for the 1950 Annual Meeting in Cleveland, May 16, 17 and 18. Members of The Council were assigned to the various Instructional Courses and the Medical Topics of the Day for the purpose of calling such sessions to order and introducing the Moderators.

It was the sense of The Council that it would be advisable to try to hold the 1952 Annual Meeting in Cleveland rather than in Columbus because of the lack of adequate facilities at the present time in Columbus. The Executive Secretary was instructed to take up this matter with the Cleveland Convention Bureau and to present a report to the Reference Committee on Time and Place of Annual Meeting at the time of the 1950 Annual Meeting.

OHIO MEDICAL INDEMNITY

Mr. Coghlan and Mr. Nelson reported on the recent meeting of stockholders of Ohio Medical Indemnity, Inc. They announced that all members of the Board of Directors had been re-elected and that Mr. Walter H. Allman, Canton, had been elected to the Board to succeed the late Judge Henry Harter. At the annual meeting of the Board of Directors immediately following the stockholder's meeting, all of the officers of the company were renominated and re-elected. **(See report elsewhere in this issue.)**

The following communication dated April 20, 1950, from Mr. Coghlan, executive vice-president of Ohio Medical Indemnity, Inc., was read and discussed:

"For your information the following resolution was passed by the Board of Directors of Ohio Medical Indemnity, Inc., at its annual meeting held on April 19, 1950.

> "Resolved, That the Board of Directors of Ohio Medical Indemnity, Inc., recommends that prompt study be given to the feasibility and advisability of the development of a plan, within the present structure of Ohio Medical Indemnity, Inc., whereby the amount of the indemnity payable under the Subscriber's contract would be accepted by the physician rendering the service as full payment in those cases in which the subscriber's gross annual income is less than $---------- (to be determined).
>
> "The Board of Directors of Ohio Medical Indemnity, Inc., further recommends that this resolution be transmitted to The Council of the Ohio State Medical Association, with the request that this Council advise the Board of Directors of Ohio Medical Indemnity, Inc., of its wishes in this matter."

On **motion** duly made, seconded and unanimously **carried**, the question presented in Mr.

Coghlan's letter was referred to the Committee on Medical Service Plans for study and report back to The Council. In the same action the President was authorized to enlarge the membership of the Committee on Medical Service Plans if he desires to do so.

CLEVELAND SITUATION

At this point, Dr. Chambers and Mr. Lansdale were invited to report on the existing situation in Cleveland with respect to negotiations being carried on with the Cleveland Blue Cross Plan and Medical Mutual of Cleveland. They reviewed in detail the proposed expansion of the Blue Cross contract to include certain medical services, and discussed the proposal now before the Cleveland Academy of Medicine to work out an agreement with Medical Mutual of Cleveland for a service contract, providing at least 51 per cent of the physicians in Cuyahoga County would subscribe to such agreement. It was pointed out that these matters are still in the discussion stage and that no definite action had been taken to date.

On **motion** duly made, seconded and unanimously **carried**, The Council requested the Cleveland Academy of Medicine to go slowly on these matters and not to take any action without due consultation with the Ohio State Medical Association. The same action provided that the committee of the Cleveland Academy of Medicine handling such matters should be asked to sit with the Committee on Medical Service Plans of the Ohio State Medical Association when it holds conferences on the question of whether or not Ohio Medical Indemnity should be converted into a service plan.

The Executive Secretary was instructed to inform Dr. James G. Kramer, Akron, that Ohio Medical Indemnity and the Blue Cross plans of Ohio have under discussion the question of providing coverage for infants for the first 30 days after birth which would meet the problem of the prematures. No definite plan has been worked out, but these organizations realize the importance of the question and are hoping to arrive at a feasible solution, it was reported.

COMMITTEE REPORTS

Dr. Mundy and Mr. Page reported on the transactions of the Committee on Rural Health held on April 2, 1950. The Executive Secretary reported on the meeting of the Committee on Education held on the same day. The reports of these committees and the recommendations incorporated were approved.

The Executive Secretary reported on a dinner-conference held by the representatives of the Ohio State Medical Association and representatives of the Ohio State Pharmaceutical Association, Saturday evening, March 30, 1950, at the Fort Hayes Hotel. He reviewed some of the questions which were discussed in an informal way at this conference, and stated that a committee of three from the Ohio State Medical Association and three from the Ohio State Pharmaceutical Association, had been named to draft a statement of policy covering some of the points which had been discussed, such statement of policy to be presented later to the proper authority of each association for review and consideration.

DISABILITY INSURANCE

A report on a joint meeting of the Committee of Public Relations and Economics and the Committee of Industrial Health and Workmen's Compensation held in the Columbus Office on Sunday, April 16, for the purpose of considering the question of compulsory temporary disability insurance was presented by the Executive Secretary. The committee report was approved.

POOR RELIEF PROBLEM

The Executive Secretary presented a report on matters considered by the Committee of Public Relations and Economics at a meeting on the afternoon of April 16 in Columbus. He read communications, which had been considered by the committee, from the superintendent of the Salem City Hospital Association and the secretary of the medical staff of that institution. These communications asked for the opinion of The Council regarding an agreement which had been entered into by the hospital with the relief authorities of Columbiana County for the furnishing of medical care and hospitalization to indigent patients. The committee reported that it had reviewed both of these letters carefully, as well as the agreement referred to. This material also was made available to members of The Council for review and study.

STATEMENT ADOPTED

After a prolonged discussion, The Council, by **unanimous vote, adopted** the following Statement of Policy which had been drafted and approved by the Committee on Public Relations and Economics for presentation to The Council:

"In some counties in Ohio, an agreement has been entered into by the local relief agency and a hospital, providing for an all-inclusive per diem rate to be paid to the hospital for the care of persons eligible to receive hospital and medical care as a part of poor relief.

"Under the terms of this agreement, the hospital contracts to furnish for the all-inclusive rate, not only hospital services but medical services, the medical services to be furnished free by members of the medical staff of the hospital.

"The opinion of the Ohio State Medical Association on this matter has been requested.

"The Council recognizes the right of physicians to give their services without charge if they

care to do so. In fact, physicians always have done so.

"However, The Council is of the opinion that the situation under consideration involves unlawful and unethical acts, namely:

"1. A hospital which agrees to furnish medical services under the terms of a contract which provides that the hospital shall be paid for all services—hospital and medical services—received by patients admitted to the hospital, is engaged in the corporate practice of medicine which is illegal in Ohio.

"2. A physician supplying medical services in a hospital under such an agreement is guilty of violating the Principles of Medical Ethics of the American Medical Association, even though he may have consented to furnish professional services without charge.

"Therefore, The Council recommends that members of a medical staff of a hospital who may wish to enter into an agreement for furnishing professional services, with or without charge, deal directly with the patients receiving such services or with the welfare or relief agency assuming liability for the care of such patients."

LEGISLATIVE QUESTIONS

The actions and recommendations of the Committee on Public Relations on other matters referred to it, such as the need for legislation to make it easier for Ohio's medical schools to secure unwanted dogs for scientific experimental purposes, multiple screening tests and other miscellaneous question, were approved by The Council.

A communication from Dr. Edward L. Burns, Toledo, on behalf of the Ohio Society of Pathologists was read and discussed. The communication pointed out some of the problems confronting pathologists, especially that the practice of pathology can be carried on in Ohio by those who do not hold a license to practice medicine. Dr. Burns' communication was referred to the Committee of Public Relations and Economics for study and a report back to The Council at a later date.

PRIVILEGED COMMUNICATIONS

A communication from Mr. R. Crawford Morris, chairman of a sub-committee of the Negligence Law Committee of the Ohio State Bar Association was read and reviewed. Mr. Morris' letter asked for the opinion of the Ohio State Medical Association on certain proposed amendments to Section 11494 of the General Code relative to privileged communications. The policy adopted by the Association in February, 1949, with respect to Senate Bill 151 pending at that time before the Ohio General Assembly was reviewed. On **motion** duly made, seconded and unanimously **carried**, The Council approved the amendments to Senate Bill 151 suggested by Mr. Morris; namely, the deletion of lines 20 to 31 inclusive and the insertion in lieu thereof of the following sentence: "If the patient voluntarily testifies, the physician may be compelled to testify on the same question."

The Council, **by unanimous vote**, reindorsed the Statement of Policy issued on this question in February, 1949, believing that it would cover the proposed amendments which had just been approved by The Council and would set forth the reasons for deletion of lines 20 to 31 inclusive.

WORKMEN'S COMPENSATION

Dr. Worstell, chairman of the Committee of Industrial Health and Workmen's Compensation, presented a report on the meeting of that committee held in Columbus on Sunday, April 16. The recommendations and actions of that committee were approved.

The Executive Secretary reviewed details concerning the pre-primary campaigns. Also, he suggested procedures for district conferences preceding the general election in November. His recommendations were approved.

A letter from the chairman of the Policy Committee of the Los Angeles Physicians Aid Association, asking the Ohio State Medical Association for financial support toward the construction of a home for financially dependent doctors of medicine in the San Fernando Valley, was discussed. The Council instructed the Executive Secretary to secure further information on this project, especially information as to how many former Ohio physicians would be eligible to benefits offered by the contemplated home. Pending receipt of additional information, The Council deferred action.

Dr. Davis submitted a report on behalf of the Advisory Committee to the Woman's Auxiliary. He recommended that the Ohio State Medical Association provide four prizes of $10.00 each, to be awarded at the 1950 Annual Meeting of the Woman's Auxiliary by the Advisory Committee, to local auxiliaries doing the best job of obtaining subscriptions for "*Today's Health*," formerly the magazine "*Hygeia*." On **motion** duly made, seconded and unanimously **carried**, this recommendation was approved.

BLOOD BANKS

A letter and other material from Dr. Paul I. Hoxworth, Cincinnati, president-elect of the American Association of Blood Banks, requesting the Ohio State Medical Association to endorse that organization, was considered. On **motion** duly made, seconded and **carried**, The Council endorsed the program and activities of the American Association of Blood Banks, believing that it offers an opportunity for certain communities to have an efficient blood donor program where participation in the Red Cross Blood Bank program is not feasible. In taking this action, the members of The Council expressed the opinion that the final decision as to whether a local blood bank program should be

DETAILED REPORTS OF THE ANNUAL MEETING WILL APPEAR IN THE JULY ISSUE

Detailed reports of the Annual Meeting of the Ohio State Medical Association held in Cleveland, May 16-18, will appear in the July issue of *The Ohio State Medical Journal.* This report will include detailed accounts of the proceedings of the House of Delegates, election of new officers, reports of attendance and other interesting news on the meeting.

under the sponsorship of the Red Cross or the American Association of Blood Banks should rest with the local medical society, such decision to be based on local needs and desires.

The Council reviewed a letter from Dr. Paul B. Magnuson, chief medical director of the Veterans Administration, Washington, D. C., setting forth the Veterans Administration's reasons for its present policy against dual appointments. The Council indicated its sympathy with the statements made by Dr. Magnuson, and instructed the Executive Secretary to communicate this action to certain members who had written to the Association on this question.

The Council authorized a contribution in the amount of $500.00 to the World Medical Association, covering the calendar year 1950.

ECONOMY MOVE ENDORSED

A report was presented regarding the economy program of the Office of Secretary of Defense, involving curtailment of certain armed forces hospital and medical activities. The Council, on **motion** duly made, seconded and unanimously **carried**, voiced its support of the economy program being sponsored by Secretary of Defense Johnson and Dr. Richard Meiling, medical director of the Office of Secretary of Defense, and instructed the Executive Secretary to send a communication to them, expressing the confidence of the Ohio State Medical Association in their program; and that similar letters be submitted to the American Medical Association and to other state medical societies.

A communication from the American Medical Golfing Association, asking for a contribution for prizes, was discussed. It was the sense of The Council that no contribution should be made.

Members of The Council then reported on activities in their respective Districts, after which The Council adjourned to meet in Cleveland on Monday evening, May 15.

Attest: CHARLES S. NELSON,
Executive Secretary.

**ARE YOU REGISTERED TO VOTE?
IF NOT, ACT PROMPTLY**

College of Surgeons Initiates Fellows for 1949

Following is a list of 1949 initiates from Ohio into the American College of Surgeons

Drs. Kenneth H. Abbott, Columbus; Duane E. Banks, Akron; Norman E. Basinger, Elyria; Robert C. Beardsley, Zanesville; Edward J. Bender, Cincinnati; Henry W. Brown, East Cleveland; Robert E. Brubaker, Akron; John R. Buchanan, Youngstown; Ord W. Burkholder, Toledo; Henry A. Burnstein, Toledo; Arthur K. Cieslak, Cleveland; William Dreyfuss, Cleveland; Robert H. Elrod, Toledo;

F. Miles Flickinger, Lima; Lewis O. Frederick, Dayton; Eugene M. Fusco, Columbus; Edward R. Garvin, Toledo; T. Kernan Golden, Youngstown; Aaron I. Grollman, Cincinnati; Philip B. Hardymon, Columbus; Arthur M. Harrison, Toledo; John W. Hauser, Cincinnati; Henry L. Hoffman, Cleveland; Charles E. Holzer, Jr., Gallipolis;

Richard C. Jones, Logan; Edward Y. Lakner, Cleveland; John M. Lowery, Columbus; Anne S. Master, Cleveland; John R. Master, Cleveland; Donald F. McGrath, Toledo; Richard L. Meiling, Columbus; Marvin C. Menard, Cincinnati; William G. Meyer, Columbus; Ward C. Meyers, Toledo; Alfred D. Miessner, Port Clinton; Donald A. Miller, Warren; Donald I. Minnig, Akron; Sylvester C. Missal, Cleveland; Leon F. Moldavsky, Akron;

James W. Norris, Columbus; William A. Nosik, Cleveland; Stephen W. Ondash, Youngstown; Charles M. Oxley, Dayton; George A. Palmer, Akron; Richard Patton, Columbus; Alexander K. Phillips, Youngstown; John A. Renner, Youngstown; Ernest E. Rhoads, Cincinnati; Barnet R. Sakler, Cincinnati; Franklin L. Shively, Jr., Dayton; Alcines Clair Siddall, Oberlin; Eugene J. Stanton, Elyria; Martin R. Sutler, Cleveland;

Donald A. Urban, Zanesville; George Van Buren, Akron; Richard E. Vance, Columbus; Elmer J. Wenaas, Youngstown; Daniel S. Wertheimer, Fairport Harbor; Edward Woliver, Cincinnati; William P. Yahraus, Canton; Walter E. Yingling, Lima; Howard H. Yoakem, Columbus; Glenn W. Zeiders, Canton.

Committee Activities . . .

Reviews of Questions Considered and Action Taken by Committees on Education, Public Relations, and Industrial Health Held Recently

MEETINGS of the Committee on Education, Committee on Public Relations and Economics, and Committee on Industrial Health and Workmen's Compensation were held recently at the Columbus Office.

The business transacted by these committees was reported to The Council at its meetings on April 22-23. The committee reports were approved by The Council. **(See Proceedings of The Council, page 569.)**

Following are abstracts of the important matters considered by these committees and the actions taken on them.

COMMITTEE ON EDUCATION

A meeting of the Committee on Education was held in the Columbus office on Sunday, April 2, following a joint meeting with the Committee on Rural Health.

The principle business transacted was to review the report of the Ohio study of child health services conducted by the Ohio group of the American Academy of Pediatrics. Dr. E. V. Turner, who directed the Ohio study explained various sections of the report.

It was agreed that Dr. Turner would prepare a memorandum regarding the recommendations contained in the pediatrics survey report, suggesting follow-up action, and that this memorandum would be used by the committee as the basis for a committee report to be submitted to The Council at a later date. Dr. Wilzbach and Dr. Rardin were designated to work with Dr. Turner in the preparation of this memorandum. It was agreed that the committee would meet again when this memorandum is completed, and at such time the following would be invited to sit in on the conference: Dr. Hoyer, Dr. Kramer, a representative of the Ohio Department of Health, a representative of the pediatricians and a representative of the Ohio Hospital Association.

A report from Dr. Jordan, who was unable to be present because of illness, on a meeting which he attended as a representative of the Ohio State Medical Association in Chicago in February at which the postgraduate activities of various state medical associations were discussed, was read and discussed by the committee. It was the sense of the committee that there are now too many meetings and that it would not be feasible for the State Association at this time to set up district postgraduate meetings. They felt it would be more practical for the State Association to organize teams of speakers on various subjects, perhaps in cooperation with the State Department of Health, and make such teams available for county medical society meetings or local one-day seminars under the auspices of county medical societies. The possibilities of working out something along this line were left pending for further consideration.

Dr. Rardin suggested that the State Association, under the sponsorship of the committee, consider preparing pamphlets which might be offered to physicians at cost, for mailing out with statements and other communications going from physicians to patients. Dr. Rardin left with the committee a list of subjects which are now being broadcast over Station WOSU, Ohio State University, as part of the series "Promote Your Health," and he suggested that perhaps some of these subjects might be worked up into brief pamphlet form.

COMMITTEE ON PUBLIC RELATIONS

A meeting of the Committee on Public Relations and Economics was held in the State Headquarters office, Sunday, April 16, following a joint meeting with the Committee on Industrial Health and Workmen's Compensation, at which joint meeting the question of compulsory temporary disability insurance was considered and action taken. **(See Proceedings of The Council, page 569.)**

Correspondence regarding certain problems which have arisen in connection with the furnishing of medical care to those on relief was considered.

After analyzing the questions raised in the correspondence and hearing reports on similar situations which have arisen in other counties, the committee adopted the following statement of policy to be presented to The Council for consideration and action. (Note: Received Council approval.)

> "In some counties in Ohio, an agreement has been entered into by the local relief agency and a hospital providing for an **all-inclusive** per diem rate to be paid to the hospital for the care of persons eligible to receive hospital and medical care as a part of poor relief.
>
> "Under the terms of this agreement, the hospital contracts to furnish for the **all-inclusive** rate, not only hospital services but medical services, the medical services

to be furnished free by members of the medical staff of the hospital.

"The opinion of the Ohio State Medical Association on this matter has been requested.

"The Council recognizes the right of physicians to give their services without charge if they care to do so. In fact, physicians always have done so.

"However, The Council is of the opinion that the situation under consideration involves unlawful and unethical acts, namely:

"1. A hospital which agrees to furnish medical services under the terms of a contract which provides that the hospital shall be paid for all services, hospital and medical services, received by patients admitted to the hospital, is engaged in the corporate practice of medicine which is illegal in Ohio

"2. A physician supplying medical services in a hospital under such an agreement is guilty of violating the Principles of Medical Ethics of the American Medical Association, even though he may have consented to furnish professional services without charge.

"Therefore, The Council recommends that members of a medical staff of a hospital who may wish to enter into an agreement for furnishing professional services, with or without charge, deal directly with the patients receiving such services or with the welfare or relief agency assuming liability for the care of such patients."

Also, the committee expressed the opinion that whenever and wherever possible, relief clients should be permitted to secure medical and hospital services from physicians and hospitals of their own choice in the county in which such relief clients reside. This is not possible when a relief agency contracts for services with physicians and hospitals in adjoining or nearby counties.

The committee then considered a question referred to it by The Council recommending that the committee consider the feasibility of, as well as the need for, legislation which would make it easier for Ohio's three medical schools to secure unwanted dogs for scientific experimental purposes.

Communications from the three medical schools were read and discussed. It was the sense of the committee that there seemed to be some difference of opinion among the three medical schools as to the need for such legislation. Therefore, the committee tabled the question temporarily and instructed the Executive Secretary to advise the deans of the three medical schools that the State Association would reconsider the question, providing the medical schools would come to some agreement as to the need for such legislation and would offer definite suggestions on the provisions of such a proposal. The motion also expressed the cooperation and support of the Association on a state-wide educational program, regardless of any action which might ultimately be taken on the matter of legislation.

The question of multiple screening tests, which are being done in some areas by the public health departments, was considered. A request from a county medical society, asking for the policy of the State Association, was discussed. The committee felt that it could take no action on this question at this time due to lack of adequate information. The Executive Secretary was instructed to endeavor to get additional information on this question.

Dr. Kramer suggested that the Columbus office poll the county medical societies to secure reports on what is being done locally on the matter of night calls, providing adequate medical services for emergencies, the establishment of a grievance committee, and such other matters which would be considered a part of the over-all public relations program.

Dr. Kramer also stated that he felt the distribution of literature would be more effective if each physician made it a point to give out literature from his own desk before dismissing the patient, rather than simply making literature available in his waiting room.

Mr. Saville, director of public relations, and the Executive Secretary analyzed the public relations activities of the A. M. A. and the State Association. Also, they provided information to the committee on the activities of individual physicians in the pre-primary and pre-election campaigns now going on in Ohio.

COMMITTEE ON INDUSTRIAL HEALTH

A meeting of the Committee on Industrial Health and Workmen's Compensation was held Sunday morning, April 16, 1950, following a joint session with the Committee on Public Relations and Medical Economics.

Following a thorough discussion of a number of suggestions from members for revision of certain items in the State Industrial Commission fee schedule, the committee, on motion duly made, seconded and carried, agreed as follows:

1. The assistant's fee of $10 is adequate in most cases.
2. The minimum fee for X-ray reexamination of fingers and toes should be raised to $5.
3. The fee schedule for such neurosurgical procedures as cervical laminectomy, multiple laminectomies and a pneumoencephalogram is adequate.
4. The Commission should retain its present regulation of requiring authorization for physical therapy after the first ten treatments.
5. The fee for rib fractures is adequate.
6. The schedule of fees for dermatologi-

cal services is in line with fees for other medical services.

7. The period of after-care covered by the flat fee in reconstructive surgical procedures should be reduced from six months to three months.

The above recommendations were approved by The Council on April 23.

The committee discussed the participation of the O. S. M. A. in the annual Ohio State Safety Conference, held in Cleveland last September, at which the committee provided the program for the Medical Section. It was reported that while the program was good, the attendance was small. Also, it was pointed out that it is difficult to present a program of equal interest to industrial physicians and laymen. It was recommended that if the Association is invited to participate in the Ohio State Safety Conference this year, participation should be limited to providing a medical speaker on a topic of general interest for one of the general sessions.

New Directory Shows One Doctor for Every 750 Persons in U. S.

The United States at the beginning of 1950 had one doctor for every 750 persons. This is the best showing for any nation in the world, with the exception of Palestine where a temporarily high ratio exists because of an influx of refugee doctors.

Next to the United States, the largest supply of doctors in relation to population exists in Great Britain where, based on latest available official figures, there was one doctor for 870 persons. Other countries in order are: Iceland, 890; Denmark, 950; Canada and New Zealand, 970. Other nations range from 1,110 persons per doctor to 25,000 persons per doctor, a situation which exists in China.

The ratio for this country was revealed by Dr. George F. Lull, Chicago, secretary and general manager of the American Medical Association. It was based on an estimated national population of 151,000,000 and 201,278 doctors whose names will be contained in the eighteenth edition of the American Medical Directory, to be issued about June 1.

"This is the largest physician population in the history of the country," Dr. Lull said. "The previous directory, published in 1942, showed 180,496 names for the United States. The increase is due principally to the graduation of new doctors by medical schools.

"The directory will contain 47,399 names for the first time. These additions were partially offset by 26,617 deletions for deaths or other causes.

"In 1930, there was an estimated 154,500 doctors for a population of 122,775,000, or one doctor for every 795 persons.

"Since then, the amount of medical service a physician can render has increased markedly because of technological improvements and increases in auxiliary personnel."

Dr. Lull predicted a further increase in physician population as a result of an expansion in medical school enrollment.

"On the basis of the new schools that are being organized and the expansion of existing schools that is now under way, the freshman class in the medical schools of the United States will shortly exceed 7,000 students, an all-time high," he pointed out. "The average size of the freshman class in the 10 years preceding the war was 6,016."

The new directory will contain 2,913 pages, or 112 more than the previous record volume issued in 1942. It will list the names, year of birth, medical school and year of graduation, specialty, if any, and addresses of physicians in Canada and the United States dependencies, as well as of those in the United States.

The total listing will be 219,678 physicians. The 1942 directory contained 201,272 names, including 4,209 doctors in the Philippines. The Philippines are no longer a dependency of the United States and have been dropped from the new directory.

Army Seeks Civilian Doctors for Japan, Guam and Okinawa

The Department of the Army is seeking physicians to serve in a civilian capacity in Japan, Guam and Okinawa.

The following information was furnished regarding these assignments as to location, title of position and gross salary: Japan, medical officer (general), $6,400; Guam, medical officer (general), $8,000; Guam, medical officer (general), $9,500; Okinawa, medical officer (public health), $8,000; Okinawa, medical officer (public health), $9,500; Okinawa, medical officer (roentgenology), $8,000; Okinawa, medical officer (pediatrics), $9,500.

Licensed doctors up to 57 years of age are being sought. The minimum tour of duty in Guam or Okinawa is one year; in Japan, two years. Dependents are permitted and living quarters are provided free except on Guam where a small rental charge is made. American schools for children through the high school level are provided.

Further information may be obtained through the Department of the Army, Civilian Personnel Division, 1660 E. Hyde Park Blvd., Chicago 15, Ill.

TO BE A GOOD CITIZEN, YOU MUST BE REGISTERED TO VOTE

Hospital Training Facilities . . .

Forty-five Ohio Institutions Approved for Intern Programs And 56 for Residencies, A. M. A. Council Report Indicates

THE number of internships offered in hospitals approved by the Council on Medical Education and Hospitals of the A. M. A. has increased by 246 during the past year, in spite of a decrease in the number of approved hospitals. This trend toward greater demand is a significant factor in considering the percentage of shortage of interns, the Council report points out. The full report is in the April 15 issue of *The Journal of the A. M. A.*

The report further points out that in 1946 the number of hospitals which the Council had approved was almost exactly the same as approved this year (as of April 1, 1950) 798 in 1946 and 799 in 1950. None the less, the same number of hospitals this year offered 1,372 more internships than were availabe four years ago.

Internships are offered in all but four of the states—a total of 9,370. The five leading states in number of internships offered are: New York, 1,464; California, 897; Pennsylvania, 837; Illinois, 702; and Ohio, 495. In addition to those available in the United States, there are 24 in the Canal Zone, 47 in Hawaii and 29 in Puerto Rico.

For the past two years, the percentage of internships which were vacant remained about constant, 20.5 per cent in 1948 and 19.7 per cent in 1949. This year the number of position vacancies has increased to 24.9 per cent of the total number offered. The number of vacancies reported by approved hospitals increased from 1,779 in 1949 to 2,340 in 1950. Two factors influence this increase measurably—the number of openings increased and more hospitals gave detailed information on their vacancies.

While hospitals in 11 states reported fewer vacancies than last year, 33 states and the District of Columbia reported an increase in the number of internships vacant. Some of the statistics furnished in the Council's report are based on information furnished by 96 per cent of the 799 hospitals approved while others are based on the total number. This accounts for slight variation in figures.

While Ohio is in fifth place in number of hospitals approved for internship training and in number of openings, her percentage of vacancies was highest of any of the larger states. In fact, only ten states, all with less than ten hospitals, had higher percentages of vacancies. The comparative table gives the following figures for Ohio: Number of hospitals approved last year, 44; number approved this year, 45; number of internships offered last year, 478; number this year, 495; number of vacancies last year, 128; number this year, 208; percentage of vacancies last year, 26.7; percentage of vacancies this year, 42.0.

TYPES OF INTERNSHIPS

Three types of internships are approved by the Council on Medical Education and Hospitals —rotating, mixed and straight. The Council considers that the rotating internship is most likely to provide the best basic training for the graduate, whether he intends later to enter general practice or to take further training in a specialty. It provides for supervised experience in the major clinical divisions of internal medicine, surgery, obstetrics and pediatrics, together with training in anesthesiology, roentgenology and pathology. The mixed internship offers training in two or more, but not all, of the major divisions. A straight internship is limited to supervised experience in a single major clinical division, including its related subspecialties. Approval in this category is extended in internal medicine, surgery, pediatrics, obstetrics and pathology.

LENGTH OF INTERNSHIPS

A significant factor in the present shortage of interns has been the decrease in the number of 18-month and two-year internships available, with a consequent increase in the annual demand for interns by hospitals which formerly offered appointments only on alternate years.

Only three Ohio hospitals offer 24-month internships. They are Mount Sinai Hospital, Cleveland; University Hospitals, Cleveland; and Ohio State University Hospital, Columbus. All the others offer 12-month internships.

RESIDENCY TRAINING

The Council on Medical Education and Hospitals now extends official approval for residency training in concurrence with the following 17 boards: The American Boards of Anesthesiology, Dermatology and Syphilology, Internal Medicine, Neurological Surgery, Obstetrics and Gynecology, Orthopedic Surgery, Otolaryngology, Pathology, Pediatrics, Physical Medicine, Plastic Surgery, Proctology, Psychiatry and Neurology, Radiology, Surgery, Urology, and the Board of Thoracic Surgery.

Residencies in the medical subspecialties of allergy, cardiovascular, gastrointestinal and pulmonary diseases are presently approved in concurrence with the subspecialty board concerned.

The Council also lists approved services in contagious diseases, general practice, malignant diseases and occupational medicine. A preliminary list of residencies in preventive medicine and public health is being prepared for publication in the 1951 Internship and Residency Number of *The Journal of the A. M. A.*

The report shows that there are 4,292 residency training programs being conducted in 1,079 hospitals approved by the Council. Of the 18,669 positions available, as of September 1, 1949, six per cent were reported vacant. In some of the specialties the percentage of vacancies ran much higher. They include physical medicine, with 33 per cent vacancies; pulmonary diseases, 21 per cent; psychiatry, 20 per cent; and anesthesiology, 15 per cent.

OHIO RESIDENCIES

Fifty-six non-Federal and three Federal hospitals in Ohio were approved for residency training. Following is the number of residency programs offered in non-Federal hospitals in Ohio: Anesthesiology 12; cardiovascular disease 1; contagious diseases 1; dermatology and syphilology 4; general practice 1; internal medicine 32; neurological surgery 5; neurology 2; obstetrics and gynecology 27; ophthalmology 9; orthopedic surgery 15; otolaryngology 6; pathology 25; pediatrics 5; physical medicine 1; proctology 1; psychiatry 9; pulmonary diseases 10; radiology 19; surgery 34; thoracic surgery 1, urology 7.

Following is a summary of residencies, assistant residencies, and fellowships offered in Ohio hospitals:

Children's Hospital, Akron—Orthopedic surgery 2; pediatrics 5; surgery 1.

City Hospital, Akron—Internal medicine 4; obstetrics and gynecology 5; orthopedic surgery 5; pathology 3; radiology 2; surgery 9.

Peoples Hospital, Akron—Internal medicine 5; obstetrics and gynecology 5; pathology 1; radiology 1; surgery 10.

St. Thomas Hospital, Akron—Internal medicine 1; obstetrics and gynecology 3; surgery 3.

Aultman Hospital, Canton—Internal medicine 4; obstetrics and gynecology 5; pathology 2; radiology; surgery 6.

Mercy Hospital, Canton—Anesthesiology 1; internal medicine 3; obstetrics and gynecology 3; radiology 1; surgery 9.

CINCINNATI

Bethesda Hospital, Cincinnati—Obstetrics and gynecology 4; pathology 2.

Children's Hospital, Cincinnati — Orthopedic surgery 1; pediatrics 16.

Christ Hospital, Cincinnati—Anesthesiology; internal medicine 4; neurological surgery 1; pathology 1; psychiatry 1; surgery 7.

Cincinnati General Hospital—Dermatology and syphilology 9; internal medicine 29; neurological surgery 2; neurology 1; obstetrics 6; ophthalmology 3; orthopedic surgery 5; otolaryngology 2; pathology 6; pediatrics 16; psychiatry 22; radiology 8; surgery 17; urology.

Deaconess Hospital, Cincinnati—Internal medicine 2.

Good Samaritan Hospital, Cincinnati—General practice; internal medicine 7; pathology 1; surgery 10.

Jewish Hospital, Cincinnati—Internal medicine 8; orthopedic surgery 1; pathology 1; radiology 1; surgery 8.

Dunham Hospital, Cincinnati—Pulmonary diseases 3.

St. Mary's Hospital, Cincinnati—Surgery 3.

CLEVELAND

City Hospital, Cleveland—Contagious diseases 4; dermatology and syphilology 3; internal medicine 18; obstetrics 4; gynecology 2; ophthalmology 2; otolaryngology 2; pathology 6; pulmonary diseases 2; radiology 6; surgery 18; thoracic surgery 2; urology 2.

Cleveland Clinic Foundation Hospital—Anesthesiology 6; dermatology and syphilology 5; internal medicine 25; neurological surgery 6; neurology 4; ophthalmology 3; orthopedic surgery 7; otolaryngology 4; pathology 11; physical medicine 1; psychiatry; radiology 9; surgery 13; urology 5.

Cleveland State Receiving Hospital—Psychiatry 1.

Cleveland State Hospital—Psychiatry 1.

Fairview Park Hospital, Cleveland—Internal medicine 2; obstetrics 2.

Lutheran Hospital, Cleveland—Internal medicine; obstetrics 2; radiology 1; surgery 8.

Mt. Sinai Hospital, Cleveland—Anesthesiology 2; internal medicine 2; obstetrics and gynecology 2; orthopedic surgery 1; pathology 2; radiology 2; surgery 4.

St. Alexis Hospital, Cleveland—Internal medicine 2; radiology 1; surgery 6.

St. Ann's Maternity Hospital, Cleveland—Obstetrics 4.

St. John's Hospital, Cleveland—Internal medicine 4; obstetrics and gynecology 4; radiology 1; surgery 6.

St. Luke's Hospital, Cleveland—Anesthesiology 2; internal medicine 5; obstetrics and gynecology 4; ophthalmology 1; orthopedic surgery 2; otolaryngology 2; pathology 2; radiology 3; surgery 4.

Sunny Acres, Cuyahoga County Tuberculosis Hospital, Cleveland—Pulmonary diseases 6.

St. Vincent Charity Hospital, Cleveland—Internal medicine 4; pathology 1; radiology 2; surgery 10.

University Hospitals, Cleveland—Dermatology and syphilology 3; internal medicine 23; obstetrics and gynecology 12; ophthalmology 3; orthopedic surgery 2; otolaryngology 3; path-

OHIO HOSPITALS APPROVED FOR INTERN TRAINING, WITH NUMBER OF INTERNSHIPS AVAILABLE AND OTHER PERTINENT DATA

	Control	Capacity	Total Patients Admitted	Type of Internship	Internships	Affiliated Service	Outpatient Service	Autopsy Percentage	Stipend
City Hospital, Akron	NPA	418	14,858	R	15	(213)	Req	42	30
Peoples Hospital, Akron	NPA	210	9,981	R	6	(171)	Req	51	50
St. Thomas Hospital, Akron	Church	205	11,034	R	6	No	Req	45	75
Aultman Hospital, Canton	NPA	301	10,363	R	10	No	Req	65	50
Mercy Hospital, Canton	Church	235	10,662	R	8	No	Req	36	75
Bethesda Hospital, Cincinnati	Church	218	8,690	R	8	(172)	Req	45	75
Christ Hospital, Cincinnati	Church	372	11,260	R	16	(172)	Req	43	50
Cincinnati General Hospital	City	850	15,449	R-S	48	(267)	Req	54	-----
Deaconess Hospital, Cincinnati	Church	168	5,112	R	5	(173)	Req	26	100
Good Samaritan Hospital, Cincinnati	Church	556	16,783	R	18	No	Req	48	60
Jewish Hospital, Cincinnati	NPA	264	12,763	R	10	(232)	None	65	50
St. Mary's Hospital, Cincinnati	Church	200	5,001	R	5	No	Req	31	75
City Hospital, Cleveland	City	1,044	11,457	R	24	No	Req	41	40
Evangelical Deaconess Hospital, Cleveland	Church	140	6,615	R	3	No	None	18	75
Fairview Park Hospital, Cleveland	Church	150	9,102	R	6	-----	Req	37	75
Glenville Hospital, Cleveland	NPA	120	4,474	M	4	No	Req	32	75
Lutheran Hospital, Cleveland	Church	133	5,181	R	8	No	None	43	50
Mount Sinai Hospital, Cleveland	NPA	251	11,441	R-S	22	(233)	Req	51	50
St. Alexis Hospital, Cleveland	Church	234	10,282	R	6	No	Req	33	50
St. John's Hospital, Cleveland	Church	230	8,942	R	8	No	None	46	50
St. Luke's Hospital, Cleveland	Church	362	14,622	R	20	No	Req	42	30
St. Vincent's Charity Hospital, Cleveland	Church	296	7,729	R	14	(214)	Req	32	50
University Hospitals, Cleveland	NPA	797	22,380	S	20	No	Req	58	-----
Doctors Hospital, Cleveland Heights	NPA	165	6,635	R	12	-----	Req	44	100
Grant Hospital, Columbus	NPA	290	10,628	R	8	No	None	34	-----
Mount Carmel Hospital, Columbus	Church	282	10,789	R	8	(174)	None	41	50
Ohio State University Hospital, Columbus	State	279	8,847	R-S	23	(175)	Req	78	9
White Cross Hospital, Columbus	Church	350	11,302	R	10	No	None	46	50
Miami Valley Hospital, Dayton	NPA	451	15,435	R	12	No	Req	45	50
St. Elizabeth Hospital, Dayton	Church	335	12,527	R	7	No	Req	39	125
Huron Road Hospital, E. Cleveland	NPA	284	10,642	R	15	No	Req	40	50
Mercy Hospital, Hamilton	Church	300	8,769	R	6	No	Req	35	100
Lakewood Hospital, Lakewood	City	129	5,942	R	4	No	Req	43	75
Lima Memorial Hospital, Lima	NPA	239	6,359	R	6	No	None	22	100
St. Rita's Hospital, Lima	Church	300	11,372	R	8	No	Req	36	100
Springfield City Hospital, Springfield	City	266	10,915	R	7	No	Req	46	100
Flower Hospital, Toledo	Church	170	5,643	R	5	(149)	None	30	150
Maumee Valley Hospital, Toledo	County	292	4,011	R	8	No	Req	52	75
Mercy Hospital, Toledo	Church	284	12,191	R	10	No	Req	45	100
Riverside Hospital, Toledo	NPA	154	5,604	R	4	-----	-----	31	100
St. Vincent's Hospital, Toledo	Church	310	10,990	R	10	No	Req	38	100
Toledo Hospital, Toledo	NPA	266	9,495	R	10	No	Req	57	75
St. Elizabeth's Hospital, Youngstown	Church	330	12,862	R	10	No	Req	40	100
Youngstown Hospital, Youngstown	NPA	627	20,250	R	15	No	Req	55	25

In the above table, the following abbreviations are used: **NPA**—nonprofit association; R—rotating internship, which is defined as one which provides supervised experience in internal medicine, surgery, pediatrics, obstetrics and their related subspecialties, together with experience in laboratory and radiologic diagnosis; S—straight internship, which is defined as one which provides supervised experence in a single department, although it may include limited opportunity for work in a related subspecialty; M—mixed; Req—Required.

Key numbers under the heading "Affiliated Service" indicate the following affiliations: (149) Children's Hospital, Columbus, pediatrics; (171) Children's Hospital, Akron, pediatrics; (172) Children's Hospital, Cincinnati, pediatrics; (173) Cincinnati General Hospital, contagious diseases and pediatrics; (174) Children's Hospital, Columbus, pediatrics; (175) Children's Hospital and St. Francis Hospital, Columbus, pediatrics, medicine, surgery; (213) Children's Hospital, Akron, pediatrics; (214) St. Ann's Hospital, Cleveland, obstetrics; (232) Cincinnati General Hospital, pediatrics; (233) City Hospital, Lakeside Hospital, Cleveland, tuberculosis, contagious diseases; (267) Chronic Disease Hospital, Cincinnati, chronic diseases, and Dunham Hospital, tuberculosis.

Internships are for 12 months with the following exceptions: Mount Sinai Hospital, Cleveland; University Hospitals, Cleveland; and Ohio State University Hospital, Columbus, each 24 months.

ology 7; pediatrics 10; psychiatry 4; radiology 5; surgery 19; urology 1.

Woman's Hospital, Cleveland—Anesthesiology 1.

Windsor Hospital, Chagrin Falls—Psychiatry 2.

COLUMBUS

Benjamin Franklin Hospital, Columbus—Pulmonary diseases 6.

Grant Hospital, Columbus—Pathology 1.

Mt. Carmel Hospital, Columbus—Internal medicine 5; obstetrics 3; orthopedic surgery 1; surgery 2.

Children's Hospital, Columbus—Orthopedic surgery 2; pediatrics 11.

Columbus State Hospital, Columbus—Psychiatry 8.

St. Ann's Maternity Hospital, Columbus—Obstetrics 2.

St. Francis Hospital, Columbus—Surgery.

Ohio State University Hospital, Columbus—Anesthesiology 3; internal medicine 15; obstetrics and gynecology 6; ophthalmology 4; otolaryngology 2; pathology 4; radiology 5; surgery 20; urology 3.

White Cross Hospital, Columbus—Cardiovascular diseases 1; internal medicine 2; neurological surgery 2; obstetrics 3; orthopedic surgery 3; pathology 2; surgery 3.

OTHER CITIES

Miami Valley Hospital, Dayton—Internal medicine 3; obstetrics 1; pathology 2; radiology 2; surgery 5.

Huron Road Hospital, East Cleveland—Anesthesiology 6; internal medicine 3; pathology 1; surgery 7; urology.

Elyria Hospital—Orthopedic surgery.

Mercy Hospital, Hamilton—Pathology 1.

Lakewood Hospital, Lakewood — Anesthesiology; internal medicine 1; obstetrics 1; surgery 3.

St. Rita's Hospital, Lima—Obstetrics 1; pathology; surgery 5.

Massillon State Hospital—Psychiatry 3.

Springfield City Hospital—Pathology 1.

Maumee Valley Hospital, Toledo—Anesthesiology 1; internal medicine 4; obstetrics and gynecology 1; surgery 5.

Mercy Hospital, Toledo—Internal medicine 1; obstetrics and gynecology 4; pathology 1; surgery 4.

St. Vincent's Hospital, Toledo—Internal medicine 2; neurological surgery 1; obstetrics and gynecology 2; orthopedic surgery 2; pathology 1; radiology 1; surgery 5; urology 2.

Toledo Hospital—Internal medicine 4; obstetrics and gynecology 4; pathology 2; surgery 4.

Harding Sanitarium, Worthington—Psychiatry 3.

Mahoning Tuberculosis Sanitorium, Youngstown—Pulmonary diseases 2.

St. Elizabeth Hospital, Youngstown — Anesthesiology 1; internal medicine 2; obstetrics and gynecology 3; surgery 7.

Youngstown Hospital—Anesthesiology 2; internal medicine 9; orthopedic surgery 2; pathology 3; proctology 1; radiology 3; surgery 12.

FEDERAL HOSPITALS

Veterans Administration Hospital, Brecksville—Pulmonary diseases 5.

Veterans Administration Hospital, Cleveland—Internal medicine 27; neurological surgery 1; neurology 1; ophthalmology 2; orthopedic surgery 7; otolaryngology 2; pathology 4; physical medicine 2; psychiatry 12; radiology 4; surgery 16; thoracic surgery 2; urology 2.

Veterans Administration Hospital, Dayton—Anesthesiology 1; internal medicine 27; pathology 1; radiology 1; surgery 15; urology 1.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since March 3, 1950. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ASHTABULA COUNTY
Robert J. Zimmerman, Conneaut

BELMONT COUNTY
Arthur A. Tesi, Yorkville
Julius M. Tesi, Yorkville
Winter T. Varner, Flushing

CLARK COUNTY
Patricia V. Adams, Springfield

CUYAHOGA COUNTY
Charles C. Althoff, Cleveland
Paul F. Boyd, Cleveland
Helmut M. Dehn, Berea
Marvin W. Evans, Cleveland
James Hare, Parma Heights
Albert A. Rayle, Jr. Cleveland
Richard L. Ruggles, Cleveland

ERIE COUNTY
Joseph P. Ohlmacher, Sandusky

FULTON COUNTY
Richard W. Deatrick, Wauseon

GUERNSEY COUNTY
Kenneth J. Frakes, Quaker City

HAMILTON COUNTY
Margaret J. Abrahamson, Cincinnati
Robert Harris, Cincinnati
Martin B. Macht, Cincinnati
William E. Shaw, Cincinnati
Thomas J. Siegel, Cincinnati
Richard J. Weber, Cincinnati

JEFFERSON COUNTY
Laura K. Mesaros, Steubenville
Paul Mesaros, Steubenville

LAWRENCE COUNTY
Joseph N. Rose, Ironton

LICKING COUNTY
David T. Williams, Newark

LUCAS COUNTY
James S. Olms, Toledo
Ernst Schmerl, Toledo
Claude A. Tallman, Sylvania

MAHONING COUNTY
Richard R. Goldcamp, Youngstown

MONTGOMERY COUNTY
Paul Beare, Dayton
Thomas Jarrold, Dayton
William S. Koller, Dayton

SANDUSKY COUNTY
Robert W. Minick, Gibsonburg
John W. Monahan, Fremont
Richard R. Wilson, Fremont

SENECA COUNTY
Emmet T. Sheeran, Fostoria

SUMMIT COUNTY
Walter H. Brown, Jr., Akron
Richard C. Curlis, Akron
William B. Rogers, Jr., Cuyahoga Falls
Leon J. Sacks, Akron
Edward A. Sawan, Akron
Leo J. Szary, Akron
Benjamin B. Wehling, Barberton

WAYNE COUNTY
Matthew O. Marks, Wooster

The Public Views the Doctor . . .

Basis for Criticisms Directed at Medical Profession Aired; How the Individual Physician Can Prevent These and Meet Existing Problems

By ROBERT W. ELWELL, Toledo, Ohio

IT has always been extremely stimulating to talk with the members of the medical profession, individually and in groups of four or five, about some of the problems that face American Medicine. To attempt to do this at this meeting may be somewhat different. At least you will probably have to wait a few minutes longer than usual for rebuttal. However, I hope we can discuss a few points in an objective manner and that you will be kind enough to interpret these remarks in the spirit they are given.

I think you will agree that lay persons who work closely with doctors and hospitals cannot help but become strong allies, staunch supporters and often zealots in protecting the position rightfully deserved by those who engage in the practice of good ethical medicine. To you who are here at this meeting, I know that your life work is not just a business or a way of making a good living, but truly a profession whose first concern is service to all those who need it. Your membership on this staff is testimony to that fact.

Now to turn to the subject at hand and why this subject. Well, it was thought that perhaps you might be interested in knowing some of the reactions that we, your employees at the Academy, receive from the public. You can appreciate that it is the logical place for people to go with their medical problems; and these problems range from selection of medical personnel to complaints of a most bizarre nature. To impose upon your good nature even more, let us enlarge the scope of this field to include the contacts that one has in the business and the social world.

Let us bear in mind that for some years now, and perhaps for many more, hunting permits read "open season on doctors." The people who are taking the pot shots—and there is a fair-sized army of them—are probably doing so for a number of reasons. Here are examples, just to mention a few: An unfortunate experience with a doctor or hospital; an expensive medical experience; inability to secure a doctor in emergencies (a high percentage of these are not emergencies, but you can't convince the family of this fact); and the most important factor of all, the attention that is being focused upon the profession by Messrs. Truman, Ewing, etc., and by some newspapers, magazines and the radio stations. For instance, that article in the December issue of *Harper's*, entitled "The Dogged Retreat of the Doctors" by Milton Mayer, is a most cynical article which serves only to poison the minds of persons who accept the writer's sarcastic remarks as fact without further investigations.

Mr. Elwell is Executive Secretary of the Toledo Academy of Medicine. The accompanying article is the text of an address which he made at the annual meeting of the staff of the Maumee Valley Hospital, Toledo.

SOME COMMENTS

Briefly, let us consider some of the unfavorable comments that come our way:

High Fees: That is probably the most frequently mentioned gripe about the profession in general conversation, but interestingly enough when specific complaints are lodged, this is not the basis in the proportion you would expect. It is rather small. However, it takes only a few doctors charging exorbitant fees to brand the whole profession with the dollar sign.

It has been my personal experience in talking with people from the hills to the river banks, that many, many times they unconsciously use the high fee as a point on which to vent their dissatisfaction that actually arises from another source.

For example, a businessman complained of what he thought was a high fee for a so-called minor operation on his child. After full discussion, it was very apparent that he was well able to pay the fee and that he had desired the services of a specialist. The child came through the operation and convalesced quickly. He and his wife were grateful for the skill of this doctor in operating on their child, but in the final analysis, the specific complaint was that when the operation was completed, a nurse announced to the anxious parents that the child had come through the operation all right. The parents wanted this assurance from the doctor, not the nurse. The father never did meet the doctor.

This illustrates a point which is too often overlooked by the physician. A few words and a friendly handshake in situations of this kind will do a great deal to break down resentment

of the profession and take it out of the assembly line production class.

DOUBLE-DIP

There is another type of complaint where the physician knowing the patient is covered by surgical insurance will increase his fee and reap the benefits from that added protection. Allow me to recite just one of several cases that have come to our attention. A patient was referred to a surgeon for an appendectomy. The surgeon, knowing that the patient was insured with the doctor's own plan, Ohio Medical Indemnity, rendered a bill for $200. When questioned by another doctor why this fee was larger than his usual charge his explanation was that the patient would receive $100 from the insurance plan and it would mean that the patient would have to pay out only $100 of his own money.

If this reasoning is to be considered valid then one wonders just how to answer a query from the public like this . . . "Why should we follow the advice of the medical profession and buy prepayment insurance only to find ourselves still paying out of our pockets about the same for medical services, plus the insurance premiums?" Here again is that very small percentage which gives the public another opportunity to condemn the doctors over bridge tables, telephones, at the shop and in the office.

EMERGENCY CALLS

The public expresses itself on another point more frequently than we like to hear. The alleged refusal to make house calls has been a problem all over the country for the past few years. This has made for bad public relations and needlessly so, in many cases. There is no reason for any person in this community not being able to secure the services of a doctor on a bona fide call. The difficulty has been in getting to the right source.

Most lay people will accept the fact that all doctors cannot make calls at all times and that some doctors do not feel best qualified to go on calls. Instead of a flat refusal to make a call, the patient or relative in most cases would accept a reasonable explanation and appreciate assistance in locating an alternate doctor. That assistance, which many of you give by calling an alternate or having the Academy send a doctor, would take the poison from the barbs that are thrown our way.

Another factor in this picture that has many ramifications is the much-repeated complaint by the patient that "I pay my good money, get a few minutes of the doctor's time, a hurried exit and no information." We, no doubt, can thank most of the magazines for giving the public a second-rate medical education. Be this good or bad, there has been a change brought about whereby many patients of today want to know about their illnesses. I don't mean to infer that it would be good practice to go into full details. Perhaps a few words properly chosen by the doctor to fit the situation would counteract such expressions as "I wonder if the doctor knows what is wrong with me"; "How long will he keep me coming"; "I'm not so dumb that I couldn't understand a few things"; "The doctor is too busy making money to spend any time with me"; "Medicine is sure a good racket these days."

We can't stop all of these remarks but a small amount of "lip service" would be the most potent factor in building greater confidence on the part of the patients.

UNNECESSARY CRITICISM

It has been a surprise to us at the Academy to have a goodly number of patients tell us that Doctor "B" says that Doctor "A" did a poor job or that the work never should have been done at all; or the wrong treatment was prescribed. It is interesting to note that in most of these cases discredit in the patients' eyes not only falls upon Doctor "A" but also upon Doctor "B" for they feel he is attempting to be superior or inflating his ego. Although he may be very sincere in his statements the patients again misinterpret the doctor's words. It would appear that from the many reactions we have had in this regard that a derogatory reference about a colleague's work helps no one and hurts everyone.

ITEMIZED STATEMENTS

We have wondered how common is the practice of rendering statements to the patient with just a total figure placed after the standard clause, "For Professional Services Rendered." To itemize services on a statement, particularly when there is a large bill, may be conducive to better understanding on the part of the recipient.

This situation was brought to our attention by a man who called one day to ask if a charge of $50 for supposedly two office calls was not exorbitant. If further explanation were not forthcoming this could be presented to the public in just that light and you can imagine the conversations that would follow.

The true picture was this: His wife had been having intestinal distress. The family doctor, and he had been their doctor for many years, made a rather complete examination on the first office visit and admitted the patient to the hospital the following day. A work-up was done under the direction of the family doctor over a period of days. A surgeon was called in and he removed the gallbladder as indicated. The important point which the complaining party, being unfamiliar with medical practice, overlooked is: The family physician did all of the preoperative and postoperative work; the surgeon did only the surgical procedure for which he charged $100. It should be mentioned that

due to some complications more than the usual amount of postoperative care was needed. It was pointed out to the husband that if the surgeon had the case from the beginning his regular fee would have been $150.00. There actually was no more outlay of money because of two doctors being on the case. This family did not understand for what the charges were and upon explanation were more than satisfied.

There is a sequel to this story. It was reported to us that when he first asked the doctor about the statement for $50, he was told curtly that his wife had come through the operation very nicely and that was the important thing. Failure to explain the charge did not hurt the family pocketbook, but it caused concern that the doctor had been sharp with them.

In the final analysis the important thing was that the relationship between doctor and family should not be clouded by misunderstanding. We received a call at a later date from this party expressing appreciation that they had re-established their former relationship with the family doctor.

Being a member of a profession certainly limits one in the manner in which he can handle people. It is apparent that people do expect the doctor to be very professional at all times. When a complaint is lodged with a doctor and he should step out of character in handling the situation, he is immediately chastised as being very unprofessional. We certainly do not envy any doctor the task of handling unreasonable patients, but they are the ones who do the most talking and convincingly so sometimes.

ABILITY TO PAY

Let us refer back to a previous point for a moment, that of high fees. Many persons have called the Academy stating that they are unable to pay their doctor bills. In these situations we are discussing now, it is not a case of the fee being unreasonable but rather too many medical bills for the paying ability of the family. Most of these people appreciate the service rendered and would like to be able to pay the doctor or doctors. In any case where we or the Collection Bureau or Central Hospital Bureau have talked with the doctors there has been a most cooperative attitude and many bills have been stricken off the records.

It seems regrettable that information regarding a family's financial status is not available beforehand. In most cases, physicians want to take into consideration this factor and it is only through lack of knowledge that later adjustments have to be made. Here again the profession is often labeled unfairly when there is a definite willingness to do a charitable deed.

Some cities such as Columbus have set up bureaus in their Academy which for a small membership fee maintain and furnish this type of service.

OFFICE PERSONNEL

For sometime the Ohio State Medical Association has been aware of what they thought was a weak link in the relationship between the doctor's office and the public and so they developed the booklet entitled "A Date With the Doctor." If any of you are not familiar with it, it can be said that it serves as a guide for the secretary, nurse or receptionist, in better handling of your patients. That this is needed can be borne out by remarks such as "When I get past that battle-axe in the front office the doc treats me swell"; or "It's a wonder that doctor has anybody come back a second time with that sourpuss at the front desk." Now of course people do come back because they want to see the doctor, not the nurse. Nevertheless, this contact is identified with the doctor and certainly breeds no extra goodwill for the profession.

Because of the doctor's educational background with years of special training, the public expects him to contribute of his time and efforts in affairs of the community, particularly in those fields where he can better serve than the non-medical citizen. Generally it has not been easy to get doctors to accept this responsibility. In our community we are fortunate in having quite a few doctors who have given freely of their time to numerous activities. This number should be increased so as to lighten the load on the present wheel horses and further expand the realm of your influence.

COMMUNITY PROJECTS

Very briefly, I want to touch upon a point that has brought much discredit upon the profession from a public relations standpoint. This has to do with the Community Chest Campaign. In order to save the doctors' time, pledge cards were mailed rather than have volunteers make the contact. Two-thirds of the doctors returned their cards and the over-all increase in the amount of pledges in this group was 10 per cent. This was highly commendable, but not what people talked about. The other one-third did not return their cards, and solicitors, who were strictly volunteers, waited hours in waiting rooms only to be told curtly that the doctor was too busy to talk with them. When they were able to contact the doctor their reception was very cool and in some cases the volunteers were chastised for asking for a pledge. This even happened in front of patients. The record shows that this one-third group pledged very little. It wasn't how little they pledged that was the topic of conversation at the Chest banquet, it was the attitude of some doctors toward a Community endeavor.

Now to some of you these remarks so far

are just repetitious of that to which you have already given considerable thought; to others it may seem incredible that the public is critical of the medical profession. Those who have made the effort to feel the pulse of public opinion are alarmed.

As George Saville, director of Public Relations for our State Office, said about a year ago, and I quote, "We who are laymen working for you in the State Office and local societies, have it brought home to us day after day at the luncheon table, at social gatherings, from secretaries of other organizations and in legislative halls. We are belabored with irritating incidents and unhappy experiences, usually culminating in the statement: 'If we get socialized medicine, the doctors will have brought it on themselves.'" Mr. Saville went on to point out how unfair that statement is, but at the same time emphasized how important the individual doctor is in this public relations picture.

We have discussed rather specific complaints at this meeting and in most cases they are not difficult of solution. I know that you doctors solve even more of these problems in your everyday practice than those who are working for you in state and local offices.

DOES THE PUBLIC KNOW?

Let us pose a question or two at this point. Does the public really know that it can take its grievances to the medical profession of this county and receive consideration? Does the public have any conception of the extent to which this is being carried on by the individual doctors and medical organization?

When one knows that this is being done it is disconcerting to hear frequent remarks that the individual with a grievance against the medical profession has no recourse. The profession believes in an open door policy and welcomes the opportunity to correct abuses, make adjustments and particularly, correct misunderstandings that may arise.

There is strong evidence to support this claim such as the action taken by several states in setting up formal machinery for this purpose and just recently, a resolution adopted by the House of Delegates of the A. M. A. at the last session in Washington, commending those state associations who have established grievance committees and urging all constituent associations to adopt comparable programs.

It has been gratifying to witness the extensive and favorable editorial response in the states and communities where such programs have been adopted. Actually the machinery exists in your own society for handling these matters, but it is not generally known and so as a result many believe our door is locked when in reality that door is a swinging door.

Even in view of apparent favorable publicity, there are some things to be said against advertising the fact that you have established a grievance procedure. It may be an admission that the profession cannot correct its faults internally. Personally, I dislike the word grievance and that dates back to former experience in personnel work. In one plant we did not allow the word grievance to be used because we felt it prejudiced the parties before we entered into discussion. We talked in terms of adjustments.

WHAT ONE SOCIETY DID

For further insight into this problem I would urge every member to read an article in the January *Ohio State Medical Journal,* entitled "Fees and Public Relations." This article outlines one approach that the San Diego County Medical Society has taken to solve the delicate problems arising between doctors and patients with reference to fees.

They advocate: (1) Discussion of Fees prior to rendering a proposed service; (2) publication (to physicians only) of average fee schedules to serve as a guide for those physicians who seriously attempt to make proper charges; (3) thoughtful explanation of the patient's problem; (4) education of physicians to the importance of the problem and pressure if necessary, to bring into line the few who continue to injure the standing of the whole profession by charging excessive fees. They feel a Complaint Bureau is unnecessary and undesirable if the basic principles just outlined are carefully followed by all.

If our public relations problem was just one of specific complaints I think all that would be necessary would be for the doctors to reassure themselves that they are carrying on the practice of medicine according to the Code of Ethics and let the Professional Relations Committee handle those members who do not.

But we must realize that the problem is not that elementary. Let us be frank and realize that the widespread antagonism and ill feeling against the medical profession in general is of major consequence. It is an intangible kind of thing which is difficult to put your finger on, much less try to eradicate.

THE WHY OF FEELINGS

Let me give you a typical example—and the end result could be duplicated in a majority of cases. While engaged in conversation with a lay acquaintance some time ago, he interrupted to ask me who a certain party was across the room. It happened to be a doctor whom he did not know and that started things rolling in another direction. Now this person, a college graduate, an intelligent person and owner of a profitable business, expressed quite strongly this attitude I have just mentioned. Upon further questioning he spoke freely of his family doctor with the highest praise and confidence. As for the

cause of his feeling about the profession as a whole, he could give no reason and was somewhat nonplussed to realize he had such deep feelings on the subject and yet could not explain why.

This conversation served to arouse sufficient curiosity on my part to try to find out in subsequent off-the-record interviews some of the causes for this feeling. In an attempt to summarize these conversations it would appear that the financial success that the doctors have enjoyed for some time now is cause for the public to feel that the doctors have become a privileged group. The public retaliates with coldness to the profession as evidenced by remarks that were made about the impersonal attitude of doctors toward their patients. The superior attitude of doctors not only in their professional work but also in other contacts was a cause given by others.

The fact that the doctors living in some of the nicer sections of our community, having nice cars and good standards of living are only a small percentage of the citizens of these sections, does not temper the feeling of people. If you make a better than average living as a contractor, salesman, owner or executive of a business or even a lawyer, people think little about it. Being in a profession that services people when they are ill seems to have some adverse influence on the attitudes of many of our critics.

For example, if a merchant sells a thousand dollars worth of furniture to a family they are not critical of the profit he makes, but if a doctor is called upon to administer to a sick member of that same family they may resent his financial success; not taking into consideration the investment the doctor makes, the responsibility of life and death, the long hours, interrupted nights, loss of time with his family and many other unpleasant phases that go to make up the practice of medicine as you know it.

Perhaps psychologically many people let emotions govern their logic and as a result still correlate on a general basis sickness with poverty. When people buy material things the salesman convinces them they have bought a good product and something they need or will want. Medical care certainly holds or should hold priority on most people's list of needs. Have the doctors done a good job of selling their patients on the value of their services? What is more important to any family than good medical care?

HUMANITY FIRST

I would like to pass on one remark that was made in the above interviews by a person who is unalterably opposed to socialism in any form and is actively fighting to stem the tide toward a totalitarian state. In speaking of the doctors he said, "I believe that every man should have the right to work and strive for his niche in this world be it large or small, but he should maintain the greatest degree of humility."

This has been a rambling kind of talk, not said very eloquently as many of you could have done, but said with the sincerity of one raised in a professional man's home. That is a heritage for which I will always be thankful because when one speaks critically of the medical or dental profession, that is criticism of those I admire the most.

In conclusion may I add . . . we have many problems facing us today but the most important issue the people of our country must decide is whether they want a controlled state or a liberal democracy. That medicine has been made the battleground may be a good thing. There is no doubt in my mind that if every doctor appreciates his responsibility in this struggle the verdict will be for freedom.

As Bill Vaughn, editorial writer for the *Kansas City Star*, so aptly put it in talking to the doctors in his city, "And yet, many a man who would never think of selling out the warm, friendly human being who is the doctor we all know and love, frankly doesn't care whether the efficient machine in the white coat is socialized or not . . . because he feels the machine doesn't give a damn about him."

Lorain County Doing Something About Public Relations

Recent public relations activities of the Lorain County Medical Society include: sponsorship of a Blue Cross Individual Enrollment Campaign; forum on socialized medicine at meeting of the Elyria American Legion Post 12, with Dr. I. M. Hinnant, Cleveland, presenting the viewpoint of the medical profession; talks on socialized medicine at meetings of the Republican Women's Club of Elyria by Dr. Raymond L. Shilling, Democratic Women's Club of Elyria by Dr. S. D. Nielsen, president of the Lorain County Medical Society; publication of an article by Dr. Nielsen in the *Elyria Chronicle Telegram* on 'How to Get Hold of a Doctor in a Serious Emergency." Dr. Theodore Berg, Elyria, is chairman of the public relations committee of the Lorain County Medical Society.

Dr. Lawrence Peters, assistant professor in the Pharmacology Department, Western Reserve University School of Medicine, has been awarded a $25,000 grant by the Markle Foundation of New York City. The grant, payable during the next five years, is one of 48 announced to date under which $1,200,000 has been set aside to keep young doctors on teaching and research staffs of medical schools.

IF YOU'RE NOT REGISTERED TO VOTE, VISIT YOUR ELECTION BOARD

Cincinnati Acts on Rebates . . .

Academy Works Out Plan "That Wlll Be Effective in Dealing With Problem"; Authorizes Disciplinary Action in Cases of Violation

A PLAN of procedure to deal effectively with the problem of "rebates" and "kick-backs," involving disciplinary action against physicians found guilty of such practices has been worked out by the Council of the Cincinnati Academy of Medicine, with the assistance of the Cincinnati Better Business Bureau, and is now in operation.

Details of the plan are outlined in a letter which has been sent to each member of the Academy by Dr. J. Stewart Mathews, the president, reading as follows:

> Much unfavorable publicity has been given to our profession in recent years in the daily press and special articles that appeared in *The Reader's Digest* and the Sunday news supplement known as *The American Weekly*. These articles accuse some physicians of accepting monetary rebates or "kick-backs" from retail dispensers.
>
> We believe that only a small minority have been guilty of this practice but there have been enough violations to create considerable resentment against the profession which warrants forceful action to abolish this evil.
>
> The Council of the Academy of Medicine has been at work for a number of months, with the help of a special committee, in cooperation with the Cincinnati Better Business Bureau, in working out a plan of procedure that will be effective in dealing with this problem. The purpose of this letter is to acquaint all members of the Academy with Council's final conclusions in this matter and to make plain just what can and will be done about it.
>
> Each member of the Academy of Medicine signs an agreement on his initial application that he will "support the Constitution and By-Laws" of the Academy. Council now proposes to interpret this signed agreement as meaning exactly what it says. Your attention is therefore called to Article V, Section 7 of the Academy By-Laws, part of which reads that "Council shall be charged with the duty of hearing evidence of conduct unbecoming to a member of the Medical Profession; violation of the Principles of Ethics of the American Medical Association, or the rules of the Academy of Medicine . . ."
>
> Your attention is further called to Article VI, Section 4 of the Principles of Ethics of the A. M. A., which reads as follows:
>
> > "When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unethical to GIVE or RECEIVE a commission by whatever term it may be called or under any guise or pretext whatsoever."
>
> Council has adopted a resolution which puts the following rule into effect:
>
> > "The principle involved in Article VI, Section 4 of the Principles of Ethics of the A. M. A. shall be extended to include the statement that it is also UNETHICAL for a physician to accept from any lay person, firm or corporation supplying goods or services to the physician or his patient, a rebate, credit, gratuity, payment of money, material or any other special consideration whatsoever in connection with any transaction not known to the ultimate consumer."
>
> Council has also approved a Standard for Dispensing Practice for lay individuals and firms supplying optical goods or services, appliances, trusses, mechanical equipment, laboratory services, etc., same to be sent by the Better Business Bureau to all such firms known to be in these types of businesses and asking for a signed agreement to obey the rule of giving no rebates, gifts, credits, etc., of any kind to a physician. A copy of this form is enclosed.
>
> The final step taken by Council is that of authorizing the Better Business Bureau to watch for violations of these rules to make the program effective and of agreeing that when a violation is reported, Council will make a thorough investigation and if the violation is proved, the guilty member will be promptly dealt with as provided for in the Academy By-Laws, Article V, Section 7 (F), which authorizes Council to expel from membership any member guilty of conduct unbecoming to a member of the medical profession.
>
> Council wishes to stress the fact that this program of cooperation with the Better Business Bureau has been entered into for the purpose of protecting the best interests of the public and the good name of our profession. It is expected that members of the Academy will live up to their promises of practicing ethical medicine and abide by the rules of good conduct properly becoming to members of the profession. It is imperative that we enforce the high moral standards we have imposed on ourselves to justify the confidence and goodwill of the public. These resolutions became effective as of the date of this letter. Council has also authorized the Cincinnati Better Business Bureau to use this letter in its dealings with business firms.

Following are the standards for dispensing practice which the Cincinnati Better Business Bureau will circulate among individuals and firms supplying merchandise or services on order of a physician, to which such individuals and firms will be asked to subscribe.

CODE FOR MERCHANTS

Being conscious of the degree of our responsibility for the health and welfare of the users

of our merchandise or services and to the members of the medical profession whose orders we fill, and, as members of the business community, we the undersigned hereby adopt the following standards of practice and pledge ourselves to abide by the terms thereof in all our relations with each other, with the public generally and with the members of the medical profession engaged in treating human ailments and prescribing therefor.

Further we agree to cooperate fully with the Cincinnati Better Business Bureau in establishing these standards, thereby maintaining public confidence in our goods and services.

DEFINITIONS

Merchandise or services: For purposes of this agreement "Merchandise or Services" shall include lenses, frames, mountings or any part thereof supplied for the human eye and based upon prescriptions together with any services supplied in connection therewith; appliances, trusses, hearing aids, mechanical equipment, laboratory services, or any other kind of product based on prescriptions or orders received from a physician to be used by a patient.

Retail Transaction: For purposes of this agreement any transaction in which the undersigned provides any of the service to or in any way deals directly with the ultimate consumer, shall be considered a retail transaction.

Wholesale Transaction: For purposes of this agreement any transaction in which the undersigned does not provide any of the service to or deal in any way directly with the ultimate consumer shall be considered a wholesale transaction.

STANDARDS

I

We pledge that we will neither offer nor give any rebates, credits, gratuities, payments of money, materials or any special considerations whatsoever in connection with any retail transactions. It is further agreed that all retail transactions will be charged and billed directly to the ultimate consumer.

II

We agree to file in writing with the Cincinnati Better Business Bureau all our current price lists for merchandise in our special field and the servicing thereof and further agree that any deviations from these lists will also be filed in writing prior to their effective dates.

III

We agree to maintain adequate written records of all transactions, both retail and wholesale and to make such records and all supporting data available to representatives of the Cincinnati Better Business Bureau at any time during business hours. Such records shall include at least, in every transaction, the name of the doctor issuing the prescription or order, the prescription, the name and address of the person to whom issued, the date received or delivered and an itemization of the merchandise sold and services rendered and the prices charged for each.

IV

Each such retail transaction shall be evidenced by a receipt issued by us to the ultimate consumer at the time of the transaction. On request, a detailed receipt shall be given which shall show our name and address as the seller, the name and address of the purchaser, the date, the services rendered and the items sold together with the prices charged for each such service and item. A duplicate of such receipt shall be retained in our permanent files.

V

We agree to display conspicuously in our waiting or fitting room a suitable plaque or statement outlining this pledge and our adherence to it. Such a plaque or statement shall be issued by and shall remain the property of the Cincinnati Better Business Bureau and shall be surrendered to it upon request.

VI

It is further agreed that the signer may terminate this agreement at any time after thirty (30) days written notice:

Accepted this_____day of_____1950.

Firm_____

By_____

Wide Scale Study of Incomes of Physicians Is Under Way

The first full-scale survey of physicians' incomes in nine years is under way.

The study is being made jointly by the Bureau of Medical Economic Research of the American Medical Association and the Office of Business Economics of the United States Department of Commerce. The survey will cover 125,000 doctors, or about 62.5 per cent of the nation's total of 201,278.

"There is evidence that the national averages in some surveys have been too high because physicians who do not have bookkeepers to fill out questionnaires do not reply in sufficient numbers," says an editorial in the April 8 *Journal of the A. M. A.*

"Some of the previous surveys have given biased results. For example, those with small practices have not been represented properly. Accurate postwar data on physicians' incomes are needed to permit more accurate estimates of how much the American people pay to physicians."

Selection of the names will be from the punch card files of the Bureau of Medical Economic Research by a formula which eliminates any partiality. To every other name will be sent a questionnaire requesting income information for 1949.

Of the other approximately 100,000 physicians every fourth name will be chosen. To 10,000 of these will go the same type of questionnaire. The other 15,000 will receive a long form sheet, requesting information on income for the years 1945 through 1949. All are to be returned unsigned in franked envelopes.

ARE YOU AND MEMBERS OF YOUR FAMILY REGISTERED TO VOTE?

Prescription Refill Problem . . .

Druggists Discuss Legal and Professional Issues Confronting Them; Court Ruling or Legislative Action Might Change Entire Picture

"THE Refill question is probably the hottest legal and professional issue confronting pharmacy," decries the Ohio State Pharmaceutical Association, in a bulletin issued to its members. In order to clarify thinking on this important matter the bulletin issued to its members a compilation of factual information which should be of equal interest to Ohio physicians.

A recent statement that the refilling of all prescriptions are governed by regulation of the Federal Food and Drug Administration is not correct, the bulletin states, adding that "there has been no ruling or regulations on the subject to the best of our knowledge." Contrary to another report, "the Federal law has not been amended to specifically prohibit refills."

The position of the Federal Food and Drug Administration on refills is simply based upon an opinion and its interpretation of the Federal Act and its application to unauthorized refilling of prescriptions under existing law, the article points out.

PHYSICIAN'S WILL

The Federal Drug Administration believes that the following definition of a prescription is one which expresses the concensus of medical opinion, according to the understanding of the Association: "A prescription is a written expression of a physician's will and purpose that the patient be furnished with a specific quantity of a drug for use as the physician directs."

A recent check of current prescription files indicated that a good percentage of prescriptions did not contain either the name or address of the patient and a very large number did not authorize a refill "It is apparent," the bulletin continues, "that too many physicians are not familiar with the responsibility of the pharmacist under State and Federal laws and the problems which confront the pharmacist in the handling of drugs or prescriptions."

In order to overcome the unreasonable demands of some customers, certain pharmacies are posting signs as follows: "Please don't ask us to violate Federal and State laws by dispensing without a prescription, sulfa drugs, barbital, thyroid, penicillin or other restricted items. These statutes are set up for the protection of the public health—your health. This pharmacy complies with such laws and the direct orders of your family physician."

SUMMARY

The bulletin summarizes the question with the following statements:

(1) The refilling of any prescription without specific authorization from the practitioner, is an over-the-counter transaction and, as such, must meet certain labeling requirements, indicates the F. D. A.

(2) Over-the-counter sale of an ℞ legend drug without any directions is illegal based upon the U. S. Supreme Court decision in the Sullivan case.

(3) Over-the-counter sale of an ℞ legend drug with directions supplied by the pharmacist is illegal according to the F. D. A. and the issue is expected to be tested in the courts.

(4) Unauthorized refill of an ℞ legend drug—also considered illegal by the F. D. A.—is illegal after the prescription has expired.

(5) Unauthorized refill of an over-the-counter drug, the F. D. A. indicates, is legal as an over-the-counter sale, provided it is accompanied by adequate directions. If it is in the manufacturer's package, he is responsible for the labeling; if repackaged by the pharmacist, he is responsible for labeling.

ONE-THIRD REFILLS

A recent report shows that new prescriptions comprise 65.2 per cent of the prescription business, with 17.1 per cent non-refillable. Of the remaining 34.8 per cent representing refills, it was found that 74.1 per cent were refilled within one year; that 11.8 per cent were refilled within two years, and that the refills after two years were negligible.

Dr. Robert M. Zollinger, chairman of the department of surgery, Ohio State University College of Medicine, Columbus, spoke on "Indications for Surgery in Gallbladder Disease," at the annual meeting of the Illinois State Medical Society, held at Springfield, Ill., May 23-25.

American Cancer Society grants at Western Reserve University now amount to $125,335. Recent awards include one to Dr. Sidney Katz for research in tissue growth, and one to Dr. A. S. Weisberger for research in the leukemia diseases. Other studies include research in abnormalities in urine and the use of isotope tracers.

TO BE A GOOD CITIZEN, YOU MUST BE REGISTERED TO VOTE

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

NARCOTIC "DON'TS" FOR THE PHYSICIAN

Recently, the *Hennepin County Medical Society Bulletin* (Minneapolis) issued a set of narcotic "don'ts" for the physician. Being unable to do a better job ourselves, we have taken the liberty of lifting them and passing them on to Ohio physicians, with the admonition that they read them carefully and comply with them:

Don't leave prescription pads around.

Addicts want them for effecting narcotic forgeries.

Don't write a narcotic prescription in lead pencil.

Avoid writing any ℞ in pencil, many are changed to call for morphine.

Don't write for narcotics this way:
Morphine HT ½ #X or
Morphine HT ½ #10.

Several X's or zeros can be added to raise the amount. Use brackets or spelling.

Don't carry a large stock of narcotics in your bag.

Addicts are on the lookout for these in doctors' offices and cars.

Don't store your office supply where patients can get it.

Avoid storage near sink or urinal. The patient may ask for use of these.

Don't fall for a good story from a stranger claiming ailment that usually requires morphine.

The addict can produce bloody sputum, simulate bad coughs or other symptoms. Make your own diagnosis.

Don't give a narcotic ℞ to another without seeing the patient.

Addicts have posed as nurses to get doctors to prescribe narcotics.

Don't write large quantities of narcotics unless unavoidable.

Diversion to addicts is a profitable business, as much as $1 for ½ gr. M. S.

Don't prescribe narcotics on the story that another M. D. had been doing it.

Consult that physician or the hospital records whenever possible.

Don't leave ℞'s signed in blank at the office.

Signed blanks are bad practice and many have been stolen by addicts.

Don't treat an ambulatory case of addiction. Addicts must be under proper control.

Addicts go to several M. D.'s at a time. Notify the local Internal Revenue Department.

Don't dispense any narcotic without keeping a record of it.

Bedside and office administration are permitted without record.

Don't buy your office narcotic needs on ℞ blank in name of patient.

The law requires you to use an official order form.

Don't resent a pharmacist's call for information about a ℞ you may have written.

The pharmacist is held responsible for filling forgeries. Please cooperate.

HAVE YOU COOLED YOUR HEELS IN COURT?

What's your experience in answering court subpoenas? One of the editorial writers for the *Columbus Academy of Medicine Bulletin* tells about one of his in the following "get it off your chest" fashion:

"The birds are singing merrily, and all's right with the world. You arrive at the office full of zest for a well-planned productive day. There, on your desk lies—

"A subpoena. It calls for your appearance in court right now, at 9:00 a. m.

"An anguished yelp brings your secretary. You learn that it was left at 5:00 p. m. the evening before with the janitor. You get records in haste, and set out for the court house, shirt-tail aflutter.

"After peeking through the courtroom door window for a bit you gather some courage, figure out which lawyer called you, and motion him out into the hall.

"'Oh, so sorry, doctor! Didn't anyone tell you? We are impanelling the jury now. You don't need to come till we 'phone—that will probably be Wednesday or Thursday.'

"So you go back to the office to sit on records and tenterhooks till about Friday. Finally a discrete call to the lawyer's office discloses that the case was settled out of court three days before!

"The above is not just piled-up bad luck. As most readers can testify, it is about the way many lawyers do business. The neophyte perhaps may picture himself as a central actor in the courtroom drama, but after a while it be-

comes a damnable bore. Perhaps even the lawyer who subpoenaed you has not acquainted himself with your story, so he fumbles about, while all parties concerned apparently conspire to keep you from fulfilling your oath to tell the whole truth.

"The average person may not be subpoenaed twice in a lifetime, and such a contribution to citizenship is fair. But the doctor seems to stand in the runway and may be called almost monthly, usually on damage cases which are in the private, not public interest. In view of this it is highly presumptuous of the legal profession to assume that on short notice their rights are superior to those of our patients and ourselves; and that the most casual connection with a case gives them the right by subpoena to take our property, in the form of expert testimony, without personal or monetary consideration.

"It would seem to be a good spot for appropriate committees of Bar and Academy to work out a fairer plan."

Doubtless, the same story could be told, and supported by facts, in almost any county. That being the case, it is suggested that the recommendation of the closing paragraph be followed by each county medical society. In other words, have your society go into a huddle with your local bar association. The effort might conserve your time and keep your blood pressure at a minimum.

MAKING FRIENDS WITH THE PRESS IS GOOD PUBLIC RELATIONS

From reports received, officers of many county medical societies are doing a good job in public relations and are not neglecting that all-important nucleus at the center of the public relations field—the men and women of the newspapers and radio stations.

There is a tendency on the part of many persons in organization offices to wait until they have a story to publish or a broadcast to arrange before they attempt to approach the people who make these affairs go day after day.

Many society officers go out of their way to invite members of the press merely to sit in on a dinner meeting or other special affair. This gesture enables doctors and members of the press to get acquainted and at the same time to exchange some good ideas on what constitutes good public relations. Response by members of the press invariably has been favorable when this was done.

And while you're inviting the press, don't stick to the publisher of the newspaper or the proprietor of the radio station. The reporters and desk men are the ones who actually write the stories and see that they get into the paper.

A society might use the installation of officers an occasion to invite these men of the fourth estate. This will give the reporters an opportunity to get acquainted with the new officers with whom they will deal. Many other special occasions lend themselves to more or less informal get-togethers.

TOO MANY RIDING THE WAGON; TOO FEW PUSHING

One of the reasons why Socialism (or Communism) impoverishes a nation is that the process of socializing draws a large proportion of the people out of productive pursuits into parasitic careers on government jobs, an editorial in the *Cleveland Plain Dealer* asserts.

Some government obviously is necessary, the editorial points out, but as government begins to regulate the workaday lives of individuals, it grows and grows and grows.

"A benign government (our own) decides that shoes should be pegged at a given price to protect the honest workingman. A big staff of employees is necessary to see that the line is held.

"The next week the government finds that shoe prices cannot be pegged unless raw leather is put under price control, and this requires a brand new army of employees.

"Then nails, machinery, rents, and all the things which together determine the price of shoes must be similarly controlled. And then the same process must be applied to the factors which control the prices of nails, machinery, and so on.

"Everyone who lived through the government controls of the war years saw this happen on a broad scale."

The editorial continues by pointing out that in England one in nine persons is on the government payrolls, supported by the other eight (and that eight, we might add, includes housewives, children and others who are not wage earners). The editorial concludes with the observation that if the British Labor party's scheme continues, the ratio of government workers to producing workers will be half and half.

PHYSICIANS, HOSPITALS PLAY PARTS IN DECREASED MATERNAL HAZARDS

An indication of how mutual cooperation between physicians and hospitals works for the good of the public is emphasized in the almost miraculous decrease in hazards of pregnancy and childbirth during the past two decades.

That the physician has played the leading role in this decrease has been demonstrated numerous times. That the hospitals are doing their part is shown by a close relationship in various regions between maternal mortality and the number of confinements within hospitals.

The Metropolitan Life Insurance Company points out that the maternal mortality rate of 20 years ago was seven per 1,000 live births, one of the highest in the civilized world at the time. The rate was down to 1.3 per 1,000 by 1947, and currently is estimated to be about one per 1,000.

Dr. Louis I. Dublin, chief statistician for

Metropolitan, calls attention to the fact that rural mortality is higher than urban and expresses the belief that recent legislation should have the result of increasing the number of hospitals and health centers available to people in the more sparsely populated sections. With that thought in mind, he predicts a very bright future in maternal care.

MR. GREEN SPEAKS— BUT HASTILY

The Associated Press has quoted Mr. William Green, president of the American Federation of Labor, as telling a London audience that he would "rather have the United States as a welfare state than a Wall Street state."

We don't know exactly what Mr. Green means by "a Wall Street state." But, judging from the latest financial report on conditions in England we are somewhat inclined to believe that Uncle Sam has done better by "Our Nell" than has John Bull, even with the financial assistance which the latter has been receiving from the old man on this side of the pond. Wonder how many of Mr. Green's members would like to trade places with their counterparts in the British Isles? We haven't noticed any grand rush for passages on the Queen Mary.

Mr. Green has every right to battle for improved conditions for his members. On the other hand, he should be sure that what he thinks they should have is an improvement over what they already have and that in asking for changes he doesn't destroy the base on which present benefits rest and on which justifiable benefits of the future will have to rest—in brief, a sound economy.

CLAUSES IN RADIUM CONTRACTS MAY ENTAIL LEGAL ENTANGLEMENTS

In a monthly news letter, the American College of Radiology calls attention to an undesirable clause which is contained in the standard agreement of lease for radium between a supply house and contracting physicians. The clause reads as follows:

"Nothing herein contained shall be construed as an express or implied warranty that the radium leased is an effective therapeutic agent, nor any warranty as to the mechanical strength of the containers described in Paragraph 1. The Lessor shall not be liable to the Lessee, its agents, patients, employees, guests, or any other person for any injury or damage directly or indirectly arising out of or resulting from exposure to or contact with said radium, in any manner or from any cause whatsoever, and the Lessee agrees to keep and save the Lessor harmless from any and all suits or claims for such damage or injury."

The article calls attention to the fact that this clause constitutes a contractual agreement on the part of the physician to assume liability of a third party. The radiologist's professional liability insurance policy sponsored by the American College of Radiology specifically excludes liability for claims arising by reason of the contractual liability of the insured to others than his patients.

The article continues to point out that in effect this means that a malpractice claim against a physician leasing radium under a contract containing this clause could not be defended on the basis of defective radium, or a defective container, because the physician had agreed to assume liability for such defects.

In the particular instance cited, an agreement was worked out to the satisfaction of the supply house and the indemnity company. The article, however, concludes with a caution that physicians would do well to examine their leasing agreements and their insurance contracts to determine whether they have protective coverage.

Possibly the same caution would apply in regard to any other therapeutic or diagnostic agents or equipment for which the physician is under contract.

NOT WHAT YOU HAVE, BUT WHAT YOU SHARE

A newspaperman, assuming editorship of a small town newspaper, wrote: "During my stay in this town, whether it be for a year or for a lifetime, I shall endeavor to improve my community by at least one per cent."

Not much improvement, someone may say on first thought. But think what it would mean to the community if each doctor, each lawyer, each businessman and so on, would undertake to improve his community only one per cent.

Unfortunately there is not that much competition in community philanthropy. The many doctors who have resolved to make their communities better places in which to live find unlimited opportunities to work at it. Although the practice of medicine undoubtedly is number one as a time consuming profession, many doctors find relaxation by participating in various community projects.

BLESSED ARE THE POOR FOR THEY SHALL INHERIT THE DEBT

Many well-meaning persons in the lower income brackets are praising the so-called share-the-wealth programs, subsidies to farmers, and the like. What these same people don't seem to appreciate is that many of our social security benefits are coming, not from any share-the-wealth schemes, but from an ever-mounting debt which some day the poor as well as the well-to-do must settle or pass on to their children.

Collection Agencies . . .

Unfortunate Experiences Furnish Warnings That Doctors Should Deal Only With Ethical Organizations, Preferably Those Operated Locally

THE purpose of this article is twofold—to offer a few helpful suggestions to physicians who may wish to turn over delinquent accounts to a collection agency, especially to those doctors who may be new in practice, and to advise doctors to choose carefully before making an agreement with an agency. Why? Because many doctors, by not being forewarned and by dealing unadvisedly, have subjected themselves and their patients to humiliation and outright fraud.

TYPICAL CASE

"It seems I have been taken for another ride with one of these collection agencies," reads the opening sentence of one letter from an Ohio doctor on file in the Headquarters Office.

"The agent gave me to understand," the letter continues, and then relates how "sleepers" in the contract worked to the exact opposite of what the slick salesman had stated.

This doctor goes on to say that he turned over a large number of accounts to the agency with the understanding that it would charge him $3 minimum only on the cases accepted for liquidation. Instead, the agent skimmed off the cream of the accounts for collection, but charged the doctor the $3 minimum **on accounts not collected.** Then it charged him 30 per cent of the amount which had been collected.

It was the doctor's understanding that he was to receive 70 per cent of the amount collected, while the agency would get 30 per cent. As it worked out—with the agency charging for accounts not collected—the doctor received approximately 30 per cent while the agency got the lion's share.

This is only one of many similar cases.

READ THE CONTRACT

Few doctors are trained in law, and few of them are in position to spot deceptive "sleepers" in unethical contracts. Experience shows that many doctors rely on the interpretation of the contract by the salesman. The saying that "a verbal agreement isn't worth the paper it is written on" holds true in this case, especially if the doctor signs a printed contract. One contract even had this statement hidden in the proverbial small type: "It is further understood and agreed that no oral representations made by your agents shall be binding upon you."

HIDDEN CLAUSES

Based on past experience, here are some of the tricks in some contracts that may seem to the untrained as merely legal terminology, but which may gyp the doctor out of his hard-earned fees and give him a reputation in the community that he may never live down:

1. Granting full authority to the company to settle, collect, adjust and act as attorney-in-fact for the physician in handling accounts, thus giving the company power to take court action and perform special services, at **extra cost to the physician.** Some agencies routinely file suit on all accounts, thus subjecting the doctor to extra cost.

2. Charging a larger fee for accounts collected in installments than for those collected in full, thus encouraging installment collections and stretching out the procedure endlessly.

3. A docket fee on each account regardless of whether any collections are made. The doctor has no definite way of knowing what accounts the agency attempts to collect.

4. Assignment of authority to the company to endorse for deposit and collection commercial papers received from all doctors.

5. Provision that payments made direct to the physician shall be remitted by him to the company and commission charged thereon.

6. Provision that commission be paid on basis of all accounts submitted for collection, and not on the amount the company is able to collect. The word "aggregate" is tricky in this respect.

7. Repeat or follow-up contracts. Some agencies make a "trial offer." They offer to collect a dozen or so accounts and present a legitimate contract for the doctor to sign. Then after collecting these accounts at a nominal fee, the agent presents a renewal contract which he represents as "substantially the same" as the original. The tricks may be in the second contract.

8. Agreement that remittance will be made to the doctor only after full settlement has been made by the agency. The agency may collect 90 per cent of all accounts and never get around to collecting the remainder.

9. Provision that commission will be paid even if the doctor withdraws the account from the agency.

Unscrupulous collection agencies can do the doctor untold harm in the community, especially those which resort to "gangster" methods of collecting accounts. Some threaten and harry debtors until they pay up in self-defense. Some collectors make a practice of "falling into con-



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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

versation" with the debtor's neighbors or fellow employees to humiliate him into paying.

HOW TO PROCEED

Here are some suggestions to the doctor who feels that he wishes to turn over long overdue accounts to a collection agency:

Deal with a local agency—at least one that is known locally. Almost every town of any size has an ethical agency, or a neighboring town has one which operates in the area.

Use your local county medical society if it has such an agency or has an agreement with a local agency. Many societies do operate bureaus of medical economics. Others have agreements with agencies operated by the local chamber of commerce or retail merchants' association.

If you wish to deal with a commercial agency, check it carefully. Read any contract carefully before you sign it. Usually a few calls to other doctors, attorneys or business leaders in the community will give you the information you need. A few days spent in checking may save many a headache.

Investigate carefully before dealing with a commercial agency with a national hookup. Some of them are not reliable.

Agree to payment of a fee only on the basis of amount actually collected.

Licensed Through Endorsement by State Medical Board

The State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians through endorsement of their licenses to practice in other states:

January 17—Jack William Barrett, Youngstown, St. Louis Univ.; Homer Clarence Brown, Hamler, Univ. of Mich.; Robert Stewart Darrow, Columbus, U. of Oklahoma.; Robert Joseph Duffner, Cincinnati, Indiana U.; Pascal Friscia, Columbus, Royal U. of Bologna (Italy); Roy Charles Hairston, Dayton, Meharry Med. Coll.; Victor Simon Hirsch, Cleveland, U. of Penna.; James Stewart Kaufman, Cleveland, Temple U.

James Patrick Keane, Cleveland, St. Louis U.; John Alfred Knapp, Columbus, Yale U.; John Stanley Kozy, Toledo, U. of Chicago; Hubert Frank Loyke, Cleveland, St. Louis U.; Wilva Marjory McIlmoyle, Cleveland, U. of Toronto; Wilson Gault Newell, Lebanon, Northwestern U.; Carl Joseph Nicosia, Bowerston, U. of Buffalo; Joseph Norris Rose, Ironton, U. of Arkansas; Leon Schiffman, Cleveland, Friedrich Wilhelm U.

Max Schiller, Cleveland, U. of London (St. Bartholomew's); Harriett Simmons Taylor, Cleveland, Coll. of Med. Evangelists; Robert Max Taylor, Cleveland, Coll. of Med. Evangelists; Albert Annis Rayle, Jr., Cleveland, Emery U.; Harry William Clatworthy, Jr., Columbus, Harvard U.; Paul James Fuzy, Jr., Youngstown, Harvard U.; Robert Francis Schultz, Kenton, U. of Mich.; Isidor Smith, Cleveland, U. of Toronto; Harry C. Jelstrom, Bethel, New York U.

April 4—Thomas Dent Allison, Lima, Harvard U.; Kenneth D. Arn, Dayton, U. of Mich.; Clyde E. Asbury, Jr., Springfield, Northwestern U.; John W. Bengtson, Cleveland, U. of Rochester; Eleanor Smith Bozeman, Akron, Meharry Med. Coll.; Wilfred Boswald Bozeman, Jr., Akron, Meharry Med. Coll.; William C. Caccamise, Cleveland, U. of Rochester; Phillip Cohn, Toledo, U. of Iowa; Ernest Ford Crider, Toledo, U. of Louisville; Arthur M. Dalton, Toledo, Duke U.; Conrad DeBold, Dayton, Washington U.

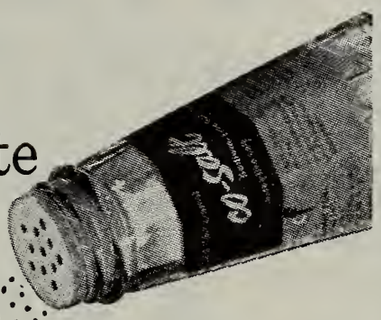
Frank J. Dzurik, Cleveland, St. Louis U.; Franklin Earnest, III, Toledo, Jefferson; Arthur Martin Edwards, Cleveland, La. State U.; Thomas D. Efstation, Tiffin, Georgetown U.; Charles Dudley Evans, Jr., Hudson, George Washington U.; Emmeleine E. Ferguson, Upper Sandusky, U. of Louisville; Robert Ross Fisher, Youngstown, Boston U.; Max D. Garber, Mansfield, Indiana U.; Abran E. Handy, Jr., Cleveland, Med. Coll. of Va.; Earl A. Hathaway, Dayton, U. of Chicago; James Fraser Jackson, East Liverpool, U. of Pittsburgh.

John R. Levitas, Columbus, Northwestern U.; Alexander Ling, Cleveland, Washington U.; Albert Ward McCally, Jr., Dayton, Columbia U.; Arthur E. McElfresh, Columbus, Cornell U.; James A. McGlew, Marion, St. Louis U.; Robert A. McLemore, Springfield, Jefferson Med. Coll.; Lester B. Mallette, Akron, Northwestern U.; Jack M. Martt, Cincinnati, Washington U.; Mary Alice Miller, Columbus, Loyola U.; Richard W. Mills, Jr., Marion, Northwestern U.; Salvador L. Mora, Toledo, U. of Berlin; George R. Nicholson, Akron, Syracuse U.

Arthur J. Patek, Jr., Cleveland, Harvard U.; Clarence J. Podore, Cincinnati, U. of Illinois; Raymond C. Pogge, Cincinnati, Northwestern U.; Frank Princi, Cincinnati, U. of Colorado; Wayne S. Ramsey, Greenville, Harvard U.; Murray Reswick, Cleveland, U. of Paris; Vernon Rowland, Cleveland, Harvard U.; Charles C. Royer, Columbus, Harvard U.; Curtis E. Sauer, Van Wert, St. Louis U.; James W. Sayre, Cincinnati, Cornell U.; Otis Blaine Schreuder, Lebanon, U. of Oregon; Joseph Schultz, Cleveland, St. Louis U.; Helen C. Sharp, Cincinnati, U. of Kansas; Seymour Simerman, Dayton, Long Island Coll.

Edna H. Sobel, Cincinnati, Boston U.; Joseph H. Stagaman, Cincinnati, St. Louis U.; Leon Stein, Cincinnati, U. of Louisville; Edward Joseph Steiner, Cincinnati, U. of Illinois; John P. Storaasli, Cleveland, U. of Minn;. Jan Schwarz, Cincinnati; German U. of Prague; Walter W. Donahue, Dayton, U. of Louisville; Heinz Eisenberg, Columbus, U. of Berlin; Robert S. Heidt, Cincinnati, U. of Louisville; Walter G. Zerbe, Cincinnati, Temple U.

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Do You Know? . . .

Western Reserve University and Case Institute of Technology agreed recently to extend the Western Reserve Health Service to cover Case students. The Health Service treats all ambulatory patients and pays for examinations, tests and consultations except dental care and eye refractions.

* * *

Dr. Burr Noland Carter, Cincinnati, was elected treasurer of the American Surgical Association at the annual meeting of the organization in Colorado Springs, Colo., in April.

* * *

Dr. William G. Myers, Columbus, is taking the leading role in a series of programs over Station WOSU, built around the general subject, "Some Medical Aspects of Atomic Explosion." The 10-weeks series began on Monday, April 3, at 7:15 P. M.

* * *

Dr. Thomas Hale Ham, assistant professor at the Harvard Medical School, was named recently to supervise a change of teaching techniques at Western Reserve University School of Medicine, according to a report in the public press. Dr. Joseph T. Wearn, dean of the School, hopes to break down the wall between preclinical and clinical training so that students may receive clinical training earlier in their course.

* * *

Dr. Frank C. Sutton, administrator of the Miami Valley Hospital, Dayton, was named president-elect of the Ohio Hospital Association at its annual meeting in Columbus. Dr. Russell B. Crawford, Lakewood, superintendent of the Lakewood Hospital, assumed office as president at the annual meeting.

* * *

The Board of Trustees of the Ohio State University College of Medicine has increased the quota of freshmen medical students from 88 to 150, effective next fall.

* * *

Dr. O. P. Kimball, Cleveland, is making a survey of nutritional needs and goiter conditions in Latin America, under the auspices of the World Health Organization. He will present his observations at a meeting of WHO in Rio de Janeiro in June.

* * *

The American Trudeau Society has named Dr. John H. Skavlem, Cincinnati, president-elect.

* * *

"The Acute Effects of Air Pollution on Human Health with Special Reference to the Donora, Pa., Episode," was the topic discussed by Dr. Wm. F. Ashe, Gallipolis, at the recent U. S. Technical Conference on Air Pollution in Washington, D. C. Dr. Ashe was special medical consultant to the American Steel and Wire Co., following the Donora disaster in October, 1948.

* * *

Dr. Walter J. Zeiter, Cleveland, has been named to fill the unexpired term of the late Dr. John S. Coulter of the Council on Physical Medicine and Rehabilitation of the American Medical Association.

* * *

Dr. E. J. McCormick, Toledo, a member of the A. M. A. Board of Trustees, was one of the United States representatives to the May meeting of the World Health Organization in Geneva, Switzerland.

* * *

Dr. Fred W. Dixon, Cleveland, was one of the guest speakers at a joint meeting of the West Virginia Academy of Ophthalmology and Otolaryngology and the Virginia Society of Ophthalmology and Otolaryngology, May 7-9, at White Sulphur Springs, W. Va. His subject was: "Diseases and Treatment of the Hard and Soft Palate."

* * *

Dr. Carl A. Wilzbach, of Cincinnati, is one of five persons elected to Honorary Life Membership this year by the American Social Hygiene Association. He was cited for the award at a luncheon meeting of the Cincinnati Social Hygiene Society on February 3.

* * *

Dr. E. Scott Hill related experiences and observations on the system of medical practice in Great Britain based on a recent trip to that country before the Canton Academy of Medicine. Dr. Hill reported that on a two-weeks' visit he talked with persons in all walks of life as well as to physicians. While the average person approves the plan on the mistaken belief that he is getting something for nothing, persons on the professional level are strongly opposed, he said.

* * *

The Committee on Medical Motion Pictures of the American Medical Association has completed a second revised edition of the booklet *Reviews of Medical Motion Pictures.* The booklet reviews and evaluates 225 films which are available to the medical profession. Copies are available for 25 cents from: Order Department, A. M. A., 535 N. Dearborn St., Chicago 10.

* * *

"Role of Antibiotics and Nutrition in the Treatment of Infection" was the topic discussed by Dr. William A. Altemeier, Cincinnati, at the Western Michigan Clinic Day, May 18, at Grand Rapids, Mich.

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Ohio Medical Indemnity . . .

Doctors' Plan Sponsored by the Association Liberalizes Contracts; Now Has More Than 740,000 Persons Covered; Officers Are Reelected

OHIO Medical Indemnity, Inc., the Blue Shield Plan sponsored by the Ohio State Medical Association, has again liberalized its contract, according to a recent announcement made by Mr. Charles H. Coghlan, Executive Vice-President.

A survey conducted by Ohio Medical in the last quarter of 1949 pointed out the necessity for these increases and information acquired in the survey served as a guide in amending the contract.

Previously, the Plan had a semiannual limit of $150 for operations due to the same illness, such as cancer and skin grafting. This limit has now been raised to $200.

In addition, a number of individual items in the schedule of indemnities were increased, the amount of the increase ranging from five dollars to fifty dollars. Some of the major surgical items previously paid at $150 and now being paid at $200 are as follows: gastrectomy, nephrectomy, abdominal perineal resection and craniotomy.

In addition, the following items in the surgical schedule were increased; radical breast amputation, removal of breast tumor, submucous resection with nasal septum, transurethral prostatectomy, dilatation and curettage, and cystoscopic examinations.

New items added to the schedule were: laminectomy, perineorrhaphy, anterior colporrhaphy and three new procedures involving multiple rectal surgery.

NEW COVERAGE CONTRACT

At the same time, Ohio Medical announced the introduction of a new contract to its subscribers. The new coverage, available at a slightly higher rate, will cover in addition to surgery and obstetrics, medical (non surgical) services for hospitalized cases. The monthly rate for the new contract is 75 cents for the single person and $2.30 for the family. Benefits are based on per diem basis for the number of days the patient is hospitalized up to a limit of 30 days per year per member. The indemnity schedule provides $5.00 per day for the first two days of each admission and $3.00 per day for the next 28 days.

The Board of Directors in authorizing the release of this new contract pointed out that the contract follows the basic principle established in the surgical contract in that it is relatively free from exclusions. Since pre-existing illnesses are covered, it was recommended that the contract be limited to group enrollment until some experience figures have been accumulated.

DIRECTORS, OFFICERS ELECTED

The annual meeting of the corporation was held in Columbus on April 19, 1950, and the Board of Directors was elected for the coming year, by the Ohio State Medical Association, sponsor of Ohio Medical. The Board of Directors is as follows: Dr. L. Howard Schriver, Dr. Robert C. Rothenberg, Dr. R. K. Finley, Dr. Carll S. Mundy, Dr. Edgar P. McNamee, Dr. Wm. M. Skipp, Dr. C. C. Sherburne, Dr. Robert T. Allison, Jr., Dr. J. Craig Bowman, Dr. Carl A. Lincke, Dr. John Marshall, Dr. H. M. Clodfelter, Dr. A. A. Brindley, Mr. Harold W. Slabaugh, Mr. James E. Stuart, Mr. H. J. Winkeljohn, Mr. D. A. Endres, Mr. E. C. Pohlman, Mr. Clair E. Fultz, Mr. Waldo M. Bowman and Mr. Walter Allman.

Officers reelected at the annual meeting are as follows: Dr. L. Howard Schriver, President; Dr. Carll S. Mundy, First Vice-President; Mr. Charles H. Coghlan, Executive Vice-President; Mr. Charles S. Nelson, Secretary-Treasurer; and Mr. Frank W. Van Holte, Assistant Treasurer.

Enrollment in Ohio Medical as of March 31, 1950, was 740,113, an increase of over 50 per cent since January 1, 1949. This means that the Ohio Doctors' Plan covers a number of persons equal to the combined populations of Cincinnati (488,000) and Dayton (252,000). Over 8,000 Ohio firms and businesses are now cooperating with Ohio Medical in making the Plan available to their employees and their families.

Ohio ranks fifth in size in the nationwide Blue Shield organization covering over 15 million Americans.

Dr. L. Howard Schriver, President of Ohio Medical, was also reelected President of the National Blue Shield organization at their recent national conference.

The American Society for the Study of Sterility will hold its sixth annual meeting in the Sir Francis Drake Hotel, San Francisco, Calif., June 24 and 25. Further information may be had by writing Dr. Walter W. Williams, secretary-treasurer, 20 Magnolia Terrace, Springfield, Mass.

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Capsules: Bottles of 25, 50 mg. each capsule. Bottles of 16, 250 mg. each capsule.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

Narcotic License Must Be Renewed By July 1 to Avoid Penalty

On or before July 1 every physician registered under the Harrison Narcotic Act, must, unless he is in military service, reregister with the Collector of Internal Revenue of the district in which he maintains an office, and pay the Federal Narcotic Tax of $1.00. Initial application may be made at any time, but existing permits must be renewed on or before July 1, annually.

PENALTIES

Failure to reregister within the time allowed by law adds a penalty to the annual tax, and in addition makes the physician liable to a fine not exceeding $2,000 or to imprisonment for not more than five years or both. In recent years the Commissioner of Internal Revenue has given some tardy registrants the choice between paying sums by way of compromise in lieu of the penalties for their offenses, or as an alternative, accepting criminal prosecution, with resultant publicity and liability to fines and possible imprisonment. Strict adherence to the law will obviate the necessity for such action and protect the physician from needless embarrassment.

FORMS MAILED

Copies of the forms for reregistration are scheduled to be mailed about June 1 by the District Collectors of Internal Revenue to each Ohio physician already registered, with brief instructions of the procedure to be followed.

Application for reregistration must be made on Form 678, signed by the physician applying and either acknowledged by two qualified witnesses or sworn to by a Notary Public or an official of the Internal Revenue Department. The physician must note on his application the number of his license to practice medicine in Ohio. The registration number assigned by the Department of Internal Revenue is retained from year to year. **Remittance accompanying the application may be in the form of cash, a postal money order, or certified check. Personal checks not certified will be returned to the sender.**

INVENTORY NECESSARY

An inventory of the narcotic drugs on hand in the physician's office must accompany the application, on Form 713. The regulations require that this inventory must be sworn to by a Notary Public or an official of the Internal Revenue Department regardless of the quantity of drugs on hand.

Inventories may be taken at any time after the receipt of the application forms each year, and may be filed as soon as completed. They must be filed by July 1.

Physicians who administer, dispense, or prescribe cannabis, must obtain a special permit under the Marihuana Tax Act, and reregister annually on or before July 1, with the Collector of Internal Revenue of his district, and pay a tax of $1.00 in addition to the regular registration fee.

MUST APPLY AFTER MILITARY SERVICE

A physician in the armed forces need not reregister. If such a physician should receive an application form for reregistration he should return it to the office of the Collector of Internal Revenue from which it was sent, together with a statement that he is in the armed forces, that he does not have in his possession any narcotics, and requesting that the registration number previously assigned to him be reserved.

Upon his return to civilian practice, a physician who has been in military service must immediately apply for registration. He will be assigned his former registration number.

New Law Liberalizes Provisions for Veterans' Home Loans

World War II veterans will find home loan benefits greatly enhanced by provisions contained in the Housing Act of 1950, recently signed by the President. Regulations and procedures to put the new provisions into effect are being drafted by Veterans Administration.

In the meantime, V. A. announced a number of changes that the new law brings about. The following are high lights of these changes.

The amount of V. A.'s guaranty on an eligible veteran's home loan is increased to 60 per cent of the loan, up to a maximum guarantee of $7,500. Previously the guarantee was 50 per cent, up to $4,000. Thus under the new law the 60 per cent ratio will apply on mortgages up to $12,500, with the guarantee remaining at $7,500 for loans over $12,500.

Gratuity payment for credit on the veteran's loan remains at four per cent of the first $4,000 of guarantee used.

Unremarried widows of veterans who died in service, or from service-connected causes after discharge, are made eligible.

Combination F. H. A.-veterans' loans will be eliminated some time in the future. According to V. A., these loans are more costly and less advantageous to the borrower than the straight veterans' loan.

The maximum period of time over which home loans may be made repayable is extended from 25 years to 30 years.

The Federal National Mortgage Association, a government agency, is given $250,000,000 in additional authority for the purchase of veterans' and F. H. A. loans made by private lending agencies. This must be used for current purchases only, and is not subject to earmarking in the form of commitments for future purchases.

Entitlement to a guaranteed loan remains available until July 25, 1957.



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Reserve Officers . . .

With Twenty Years of Service, Members of Military Components May Become Eligible for Substantial Retirement Pay at Age of Sixty

RECORDS in the Headquarters Office of the Ohio State Medical Association show that at one time during the war more than 3,100 Ohio doctors were in active military service. This figure does not include the many doctors who saw service prior or subsequent to that time, nor those who have come into the Association since. The following article, therefore, will be of interest to physicians of this State, particularly those who are now in reserve components or who may wish to continue their services to the military establishment. It is reprinted from *The Journal of the A. M. A.*

* * *

Some members of the reserve components of the Armed Services are not familiar with the retirement benefits to which they are entitled by law. Public Law 810 of the Eightieth Congress states that any reserve officer or enlisted man who has performed satisfactory Federal service for an aggregate of twenty years, the last eight of which have been as a member of a reserve component, is eligible for retirement pay on reaching the age of 60. The amount of such pay is proportionate to the highest rank satisfactorily held and to the relative number of years of active and inactive service.

SERVICES DEFINED

The term "Federal Service" as used includes all active Federal service in the United States Army, Air Force, federally recognized National Guard prior to 1933, Navy, Marine Corps, Coast Guard and all service in their reserve components other than active Federal service performed prior to July 1, 1949, except for service in the inactive National Guard or Air National Guard, in a nonfederally recognized status in the National Guard or Air National Guard or in an inactive reserve section of the Officers' Reserve Corps or an inactive officers' section of the Air Force Reserve.

The term "active Federal service" includes all periods of annual training duty, all prescribed periods of attendance at service schools and any period of active duty under orders of competent Federal authority. In other words, each year of satisfactory service prior to July 1, 1949, is considered to be a year of satisfactory Federal service without any retroactive requirement as to the duties which must have been performed, provided that this service was not performed in certain inactive components which are specifically excluded.

This law states that no one who was a member of a reserve component on or before Aug. 15, 1945, shall be eligible for retirement benefits under its provisions unless he has performed active Federal service during any portion of either of the two periods April 6, 1917, to Nov. 11, 1918, and Sept. 9, 1940, to Dec. 31, 1946.

Subsequent to July 1, 1949, however, a year of satisfactory Federal service as a member of a reserve component while not on active duty consists of any year during which a minimum of fifty points has been credited on the following basis: (1) Fifteen points, automatically granted for membership in the active reserve; (2) one point for each day of active Federal service during that year; (3) one point for each drill, meeting, instruction period and performance of physical examinations and for each day of training duty, with or without pay, and (4) various point credits for the successful completion of correspondence courses.

PERCENTAGE BASIS

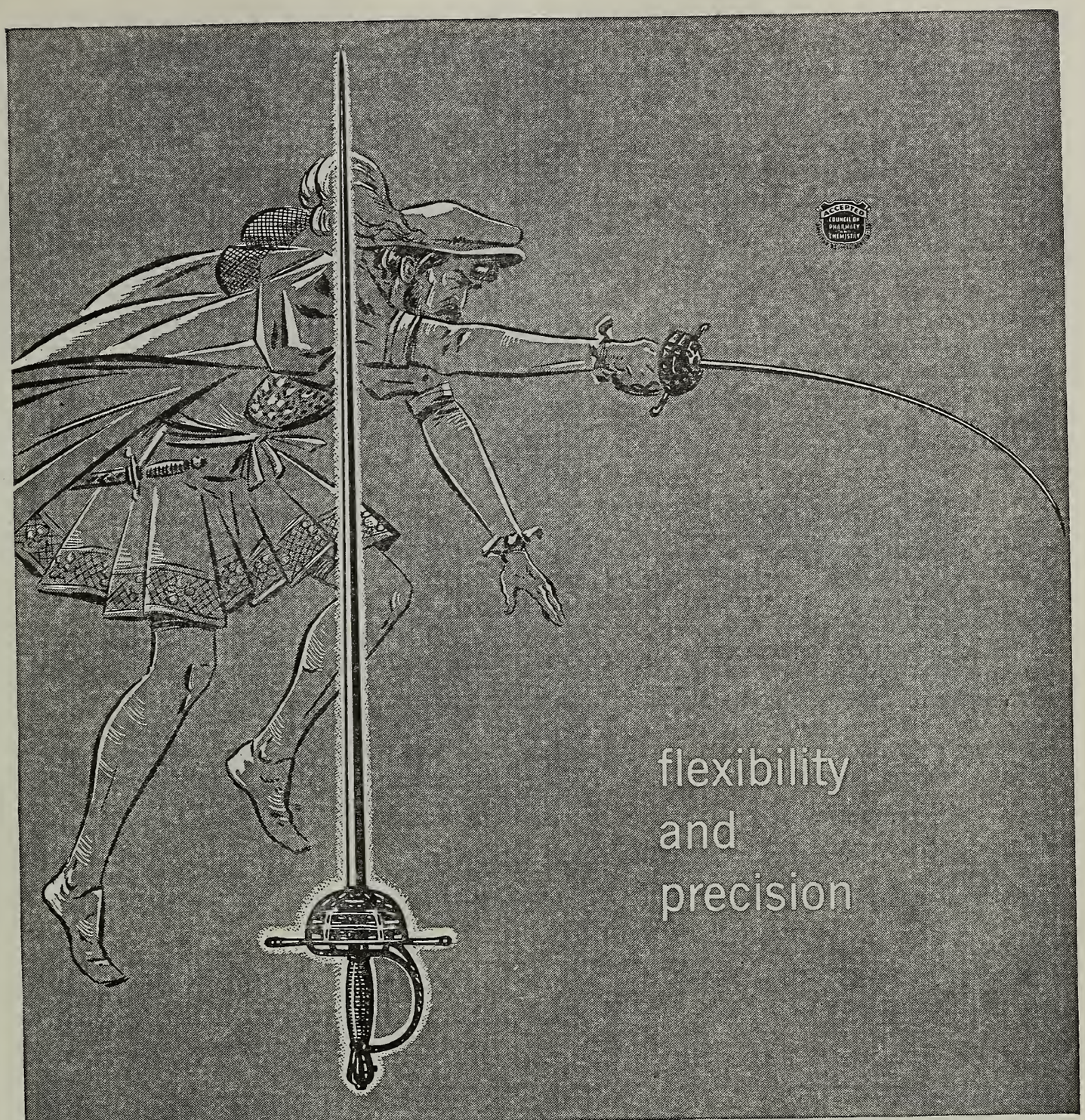
The retirement pay granted under this law equals the sum derived by multiplying 2.5 per cent of the base and longevity pay which the recipient would receive if he were serving on active duty, at the time he is granted such pay, in the highest temporary or permanent grade which he held satisfactorily during his entire period of service, by a certain factor.

This factor consists of the number of years and any fraction thereof (on the basis of 360 days per year) composing the sum of the following: (1) All periods of active Federal service; (2) fifty days for each year of Federal service, other than active Federal service, performed as a member of a reserve component prior to July 1, 1949, and (3) one day for each of the fifty points required for each year of satisfactory service performed subsequent to July 1, 1949. Not more than sixty days may actually be credited, on this basis, per year.

Anyone who has not attained the age of 60 but is eligible in all other respects to receive retirement pay under the provisions of this law may be transferred to an inactive status.

EXAMPLE

Suppose that a physician served as a reserve officer for the ten-year period ending Jan. 1, 1940. He will thus have accumulated 10 times 50, or 500 "days" during this time. Called to active duty on Jan. 1, 1940, he served five years, until Jan. 1, 1946, at which time he was released



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from active duty with the rank of colonel or its equivalent and 5 times 360, or 1,800 additional days. Remaining in his reserve component, he accumulates 3½ times 50, or 175 additional days during the three and one-half year period between Jan. 1, 1946, and July 1, 1949.

He now has eighteen and one-half years of satisfactory Federal service and needs only one and one-half more years of service to qualify for the retirement benefits under Public Law 810. To do this he must be credited with the fifty points a year required, since July 1, 1949, for a year of satisfactory Federal service. Should he do this by remaining active in the reserve program, he will receive an additional 75 (1½ times 50) days, giving him a total of 2,550 days of service over this twenty-year period of Federal service.

At the age of sixty he will be entitled to receive 2.5 per cent of $612.75, the base pay of a colonel with twenty years of service, times 7.1 (2,550 divided by 360), or $108.77 monthly, for the remainder of his life. Should he not be credited with the necessary fifty points by July 1, 1950, however, and since he may conceivably be discharged for disability during the extra year that would then be required for him to earn these fifty points, he may have forfeited the equivalent of an annuity for which he has already almost completed payment.

WHY FORFEIT ACCUMULATION?

Some younger men, unknowingly, may also be forfeiting a sum already paid by them for a similar annuity. Suppose a physician has served for one year in a reserve component and then for three years of active duty during the war, after which he has let his commission lapse.

He is credited with four years of Federal service, and, because of his youth, still has available to him the necessary time in which to serve the sixteen additional years required of him. He is probably still young enough, despite the three to four-year period that he has been inactive, to serve the required sixteen years and revert to an inactive status before the age of 60.

Since he may retire with the rank of colonel or its equivalent, he will, even though he has not served on active duty a single day during this time, be entitled to $88.86 monthly for the remainder of his life. Should he elect to serve for additional periods of active duty the amount to which he would be entitled would, of course, be greater.

A new medical detachment assigned to the Ohio National Guard, 182nd Antiaircraft Battalion, was activated recently in Dayton. Lt. Robert L. Sutton, M. C., Veterans Administration physician, is in command. Other personnel include a dental officer and 11 enlisted men.

Doctors' Orchestra of Akron Completes 24th Season

The 40-piece Doctors' Orchestra of Akron recently completed its 24th season with its 142nd concert.

Concerts were given for the Summer Home for the Aged, Children's Home, Children's Hospital, Akron City Hospital; benefit concerts for the Children's Hospital of Barberton, Our Lady of the Elms School, St. Thomas Hospital.

Director of the orchestra is Dr. A. S. McCormick and Dr. Arthur Dobkin is concertmaster. They with Dr. R. E. Pinkerton and Dr. C. P. Neff constitute the executive committee.

During its 24 years the orchestra has played for 25 hospitals, medical and dental and nursing organizations in Akron, Barberton, Canton, Columbus, Chargin Falls, Monroe Falls, Clinton, Congress Lake, Uniontown, Springfield Lake and Wadsworth. Benefit concerts were given for the City Hospital of Akron, Citizens Hospital of Barberton and Municipal Hospital of Wadsworth.

The 25th season will open in October when rehearsals are resumed.

Opinion of Attorney General

Following is the syllabus of Opinion 1607, given recently by Attorney General Herbert S. Duffy:

"Aid for the aged does not constitute poor relief, as that term is defined in Section 3391-1 et seq., General Code, as enacted by Amended Substitute House Bill No. 277 of the 98th General Assembly."

Cancer Film Available

A new film entitled "Breast Cancer: The Problem of Early Diagnosis" produced jointly by the American Cancer Society and the National Cancer Institute of the U. S. Public Health Service, is available for use at county medical society meetings and other scientific sessions. It is the second in a diagnostic series of six films on cancer. Inquiries should be directed to the Ohio Division of the American Cancer Society, local cancer societies or the Ohio Department of Health.

Medical Illustrators

The directory issue of *Graphics*, official publication of the Association of Medical Illustrators, contains the name, address, training, professional experience and reference to major published work of each member. Other information pertaining to the profession is included.

The journal, to be issued June 1, will be available to those who require medical illustration service and will be sent free of charge upon request to the editor, Miss Helen Lorraine, 5212 Sylvan Rd., Richmond 25, Va.



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Buckeye News Notes . . .

Akron—Dr. David J. Roberts addressed a group at the First Universalist Church on the theme, "The Threat of Socialization of Medicine and Business."

Bellevue—Dr. Forest R. Yohe spoke on the subject of "Socialized Medicine" before the Bellevue Chamber of Commerce.

Bluffton—"What You Should Know About Compulsory Health Insurance" was the topic of a discussion by Dr. Boyd W. Travis before the Bluffton Parent-Teacher Association.

Bowling Green—Dr. David A. Tucker, Jr., University of Cincinnati College of Medicine, spoke on the subject, "The Physician in Historical Retrospect," before the Bowling Green Chapter of Alpha Epsilon Delta.

Cadiz—Dr. D. L. Tippett spoke on the subject of "Socialized Medicine" before a meeting of the local American Legion Post.

Canton—Dr. Helen S. Brogden addressed the Canton Division of the Minute Women in Ohio in the School of Nursing, Mercy Hospital, on the subject of "Socialized Medicine."

Chardon—Dr. W. P. Edmunds, formerly of Cleveland, is the new Geauga County health commissioner. He succeeds Dr. W. C. Corey, of Chardon, part-time health officer for 25 years.

Cincinnati—Dr. Frank R. Dutra discussed "Medicine in the Investigation of Crime" at a meeting of the Cincinnati Dental Society.

Cincinnati—Dr. William L. Roach spoke on the subject, "Modern Trends in Psychiatry" at a meeting of the Alumnae Association of the Deaconess Hospital School of Nursing.

Cincinnati—Dr. Esther Marting Fabing spoke before the Women's Auxiliary of the Cincinnati Lions Club.

Cincinnati—Dr. J. Stewart Mathews, president of the Academy of Medicine of Cincinnati, introduced Dr. Donald A. Covalt, Institute of Physical Medicine and Rehabilitation, University of New York-Bellevue Hospital Medical Center, at the annual meeting of the Craft Shop of the Handicapped, in April. Approximately 300 women attended the meeting.

Cincinnati—Dr. Earl R. Bush has been appointed medical director of the Western & Southern Life Insurance Co. He formerly was associate medical director.

Cincinnati—Dr. Stanley E. Dorst, dean of the University of Cincinnati College of Medicine, spoke at the University of Cincinnati Day banquet.

Cincinnati—Dr. Joseph Lindner spoke before the Gate Club.

Cincinnati—Dr. Charles Goosmann spoke before a meeting of the Lions Club on the importance of early diagnosis and treatment of cancer.

Cleveland—Dr. Robert M. Stecher, one of the founders of the Cleveland Health Museum, was elected its president to succeed the late Dr. Lester Taylor.

Cleveland—Dr. Alan R. Moritz, Western Reserve University School of Medicine, addressed members and guests of the Women's City Club, advocating more adequate means of dealing with sex offenders.

Cleveland—Dr. Claude S. Beck addressed a meeting sponsored by the Junior League on the subject, "What Surgery Can Do for Heart Disease."

Columbia—Dr. Marion G. Fisher, Oberlin, discussed public health before a meeting of the Acme Grange.

Columbus—Dr. Robert E. S. Young discussed proposed Federal compulsory health insurance before the Northern Columbus Kiwanis Club.

Columbus—Dr. John E. Martin presented the medical profession's viewpoint in a forum on the subject, "Socialized Medicine or Federal Health Insurance" at the East Broad Street Church of Christ.

Columbus—Dr. Robert C. Kirk presented the medical profession's viewpoint on national compulsory health insurance proposals in a panel discussion at a meeting sponsored by the War Veterans Republican Club.

Columbus—Dr. Miner W. Seymour discussed "Compulsory Health Insurance or Government Controlled Medicine," at a meeting of the Business and Professional Women's Club of Columbus.

Dayton—Dr. Samuel N. Maimon spoke on "Gastrointestinal Allergy" at a meeting of the Ohio Valley Allergy Society.

Dover—Dr. C. S. Palmer, Massillon, was main speaker at the Chamber of Commerce civic award banquet. His topic was "Aggressive Citizenship—Safeguard of Freedom."

Elyria—The physician's viewpoint on "Socialized Medicine" was discussed by Dr. Raymond L. Shilling at the March meeting of the Elyria Republican Women's Club. Part of his discussion was based on observations on a recent trip to Great Britain.

Elyria—Dr. I. M. Hinnant, Cleveland, explained the medical profession's stand on "Socialized Medicine" in a panel discussion before the local American Legion post.

Findlay—Dr. John H. Marshall spoke before the Findlay Kiwanis Club on the subject of dangers of atomic bombs. Dr. Marshall recently

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attended a conference in Washington at which military and medical phases of the A-bombs were discussed.

Hillsboro—Dr. A. M. Brenner addressed the Rotary Club on the subject of "Atomic Weapons and Medicine."

Hudson—Dr. C. E. Kinney, Cleveland, spoke before the Episcopal Men's Club on the subject, "A Doctor Looks at Europe With Some Observations on Socialized Medicine."

Huron—Dr. Carl E. Swanbeck spoke before the Rotary Club, relating experiences and observations on a recent trip to Panama and the Canal Zone.

Mansfield—Dr. Harry Wain, Richland County health commissioner, addressed members of the Hedges P.-T. A., centering his talk around two moving pictures on human reproduction and human growth.

Marion—Dr. Daniel M. Murphy was named a director of the local Lions Club. Dr. Frederick T. Merchant spoke before the Lions Club on the subject, "Socialized Medicine."

Marion—Dr. Frederick W. Rea was guest speaker at a meeting of the Silver Street P.-T. A., where he explained importance of the pre-school clinic.

Mentor—Dr. I. M. Hinnant, Cleveland, spoke on "Socialized Medicine" at a meeting of the Mentor Woman's Club.

Mentor—Dr. L. Warren Payne, Willoughby, described work at the Painesville Cancer Clinic at a meeting of the Mentor Child Study Club.

Nelsonville—Dr. J. L. Webb and Dr. W. H. Hyde have been appointed to serve as joint chiefs of staff of the new Mount St. Mary Hospital.

Painesville—Dr. J. M. York has been appointed full-time medical director of the Diamond Alkali Company's Painesville plant. He formerly held the same position on a part-time basis.

Plain City—Dr. Robert A. Vogel, commissioner of the Madison-Union-Delaware Health District, spoke before the local Lions Club.

Portsmouth—Dr. Harry A. Schirrman was commended by the U. S. Weather Bureau for his nearly 47 years as official U. S. weather observer at Portsmouth, and was the subject of a feature article in the *Portsmouth Times*.

Racine—Dr. John Philson was the subject of a human interest article in the *Pomeroy Sentinel* on his 53rd anniversary in the medical profession.

Sandusky—Dr. N. Berneta Block is the new Sandusky-Erie County health commissioner.

Sandusky—Dr. Ross M. Knoble spoke before the local Kiwanis Club on the subject, "Socialized Medicine."

Veterans Administration

Veterans Administration announced organizational changes in its Physical Medicine Rehabilitation Service placing greater medical emphasis on the rehabilitation aspects of the service.

Specifically, the V. A. said, the former Educational Therapy and Manual Arts Therapy sections in hospitals and centers have been placed under the administrative and professional supervision of the Chief of the Occupational Therapy Section.

Dr. Paul B. Magnuson, Chief Medical Director of the V. A., declared the move will "increase the efficacy of these rehabilitative therapies by providing administrative and professional supervision by a person (occupational therapist) with a background of clinical training."

The professional supervision by the Chief of Occupational Therapy will make available to the physician additional important information essential for the over-all treatment of the patient.

This realignment, V. A. officials pointed out, does not alter the professional direction and responsibility of the physician in charge of Physical Medicine Rehabilitation at the hospital. Physical Therapy and Corrective Therapy sections continue reporting directly to the physician.

Manual Arts and Educational therapists will continue to utilize their professional techniques as heretofore for those patients whose illnesses require those particular types of therapy.

* * *

Bids are scheduled to be received in June for the 500-bed Veterans Administration Hospital to be built in the Wade Park-E. 105th Street area of Cleveland. Officials expect the hospital to be ready for occupancy in the early part of 1952. Cost will be approximately $5,000,000.

The new hospital will be restricted to medical and surgical cases, according to reports in the public press, and will replace Crile Veterans Hospital in that respect.

It is also planned that a new 1,000-bed neuropsychiatric hospital will be built on the present site of Crile Veterans Hospital shortly after the other hospital is completed.

The joint Veterans Commission of Cuyahoga County has recommended simultaneous construction of the two hospitals to avert any patient pinch during the interim period.

* * *

Twenty-six new Veterans Administration hospitals and 6 major additions to existing V. A. hospitals are scheduled for completion during calendar year 1950, F. H. Dryden, V. A. assistant administrator for Construction, Supply and Real Estate, announced.

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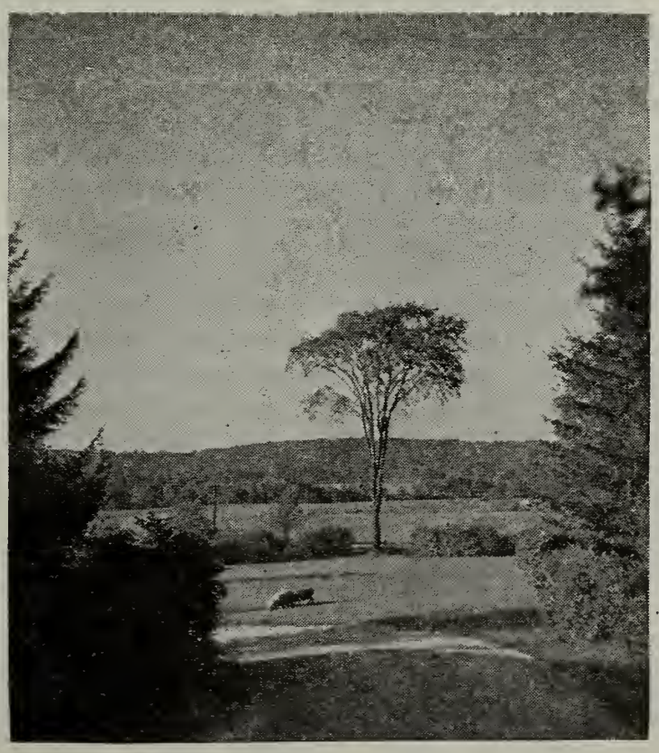
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In Memoriam . . .

William Frederick Bay, M. D., Bradenton, Fla.; Ohio Medical University, Columbus, 1894; aged 76; died March 28; former member of the Ohio State Medical Association through 1929. Dr. Bay formerly practiced at Clyde.

Henry Clay Burson, M. D., Seattle, Wash; Toledo Medical College, 1896; aged 81; died March 1. Dr. Burson practiced in Toledo and vicinity many years ago.

Ernest Fleetwood Cox, M. D., Columbus; Ohio Medical University, Columbus, 1906; aged 73; died March 8; former member of the Ohio State Medical Association and the American Medical Association through 1947. Dr. Cox practiced his profession in Columbus for approximately 44 years, and for a number of years was physician for the City of Columbus. He was a member of the Second Baptist Church and the Masonic Lodge and was a trustee of the Godman Guild. Surviving are his widow, a daughter, two sisters and two brothers.

Carl Floyd Hartmann, M. D., Wauseon; Rush Medical College, Chicago, 1909; aged 66; died April 18; member of the Ohio State Medical Association and the American Medical Association through 1947. Dr. Hartmann practiced medicine in Fulton County for almost 40 years. He served for four years as county coroner and for 29 years as county health commisisoner. A veteran of World War I, he was active in the local American Legion Post, and was active in several Masonic orders. Surviving are his widow, a daughter, a son and two sisters.

Lewis P. Jackson, M. D., Columbus; Starling Medical College, Columbus, 1898; aged 82; died February 5; former member of the Ohio State Medical Association and the American Medical Association. Dr. Jackson had retired from practice many years ago.

Frank Theodore Kopfstein, M. D., Cleveland; University of Wooster Medical Department, Cleveland, 1896; aged 83; died May 7; former member of the Ohio State Medical Association and the American Medical Association through 1946. Dr. Kopfstein had practiced medicine in Cleveland for 54 years and was among Cleveland doctors approved to receive the 50-Year Pin and Certificate of the Ohio State Medical Association. He was a member of the Episcopal Church and several Masonic orders. Three brothers and two sisters survive.

James Morris Lantz, M. D., Lancaster; Ohio State University College of Medicine, 1908; aged 68; died April 30; former member of the Ohio State Medical Association and the American Medical Association through 1947; Dr. Lantz had practiced his profession in Lancaster from 1908 until his retirement about five years ago. He was a veteran of World War I. Surviving are his widow and a son.

Harvey E. Massey, M. D., Sharon, Pa.; Starling Medical College, 1911; aged 65; died March 11 in Florida; former member of the Ohio State Medical Association and the American Medical Association. Dr. Massey practiced at Marshallville before moving to Pennsylvania many years ago.

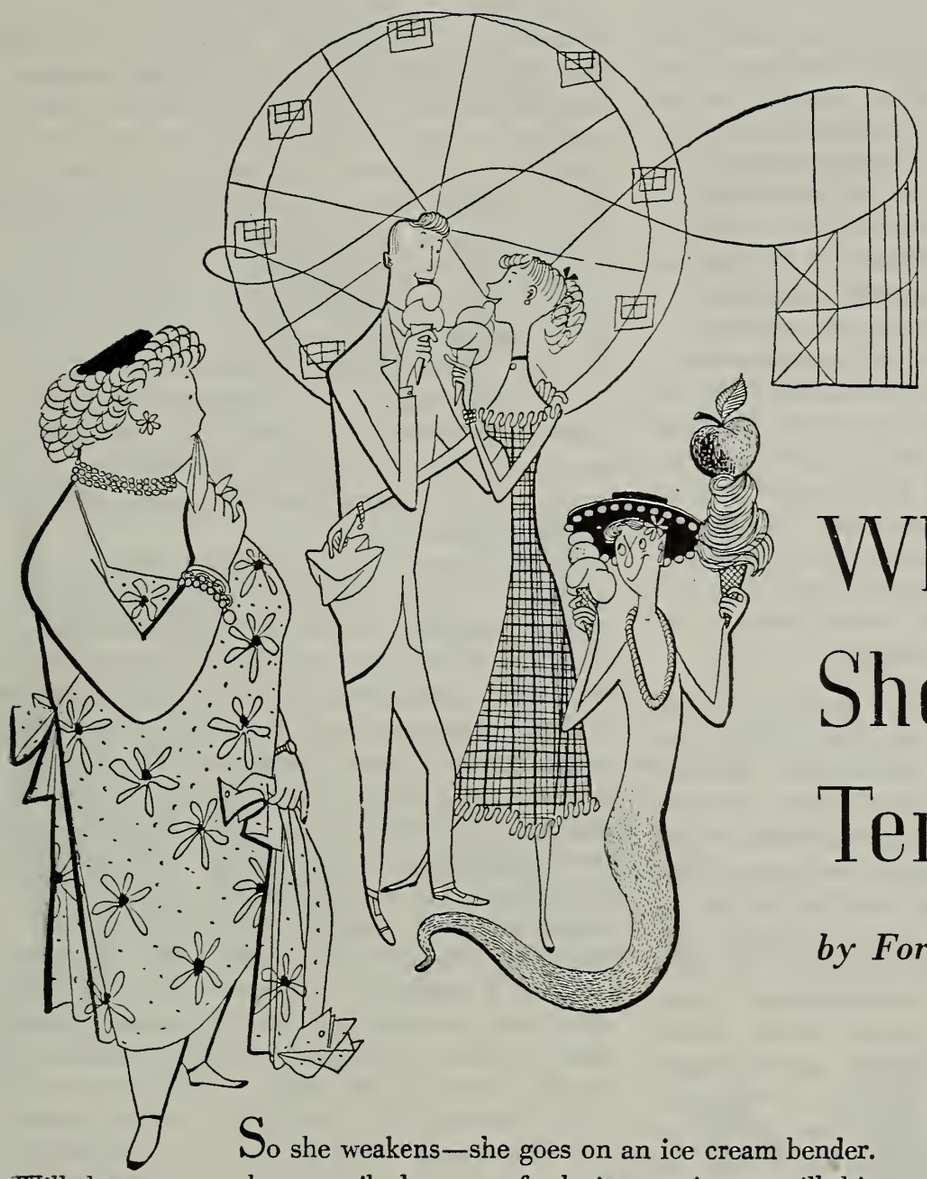
Irwin William Mayberry, M. D., Dobbston; University of Cincinnati College of Medicine, 1911; aged 63; died April 21. Dr. Mayberry formerly practiced in Huntington, W. Va., and moved to Dobbston in 1930. Surviving are a son and a brother.

Ray A. Nixon, M. D., Eau Claire, Wisc.; Ohio State University College of Medicine, 1911; aged 62; died April 25 at Fondulac, Wisc. Dr. Nixon formerly practiced in Stratton and Toronto (Ohio) before moving to Wisconsin about 30 years ago. Surviving are his widow, a daughter, two brothers and three sisters.

William Ravine, M. D., Cincinnati; Medical College of Cincinnati, 1909; aged 66; died April 11; member of the Ohio State Medical Association and a Fellow of the American Medical Association; diplomate of the American Board of Psychiatry and Neurology; member of the American Psychiatric Association. Dr. Ravine had served all of his professional career in Cincinnati with the exception of the time he served in the Medical Corps during World War I and time spent in study abroad. He was consultant to the Department of Psychiatry at Jewish Hospital and served the Court of Domestic Relations as psychiatrist. Other activities included membership in Wise Center Temple, B'nai B'rith Club and the Optimist Club. His widow survives.

William Rigelhaupt, M. D., Cleveland; Western Reserve University School of Medicine, 1911; aged 68; died April 9; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1947. Dr. Rigelhaupt was on the active staff of Lutheran Hospital. His widow survives.

Anton Benjamin Spurney, M. D., Cleveland; University of Wooster Medical Department, Cleveland, 1902; aged 71; died May 1; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1945; member of the American College of Surgeons. Dr. Spurney had practiced his profession in Cleveland for approximately 48 years. During World War I he served in the Medical Corps. He was active in the development of Polyclinic Hospital and



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had been a member of its staff since it was organized. Surviving are his widow and a son.

Orville Jackson Walker, M. D., Youngstown; University of Pittsburgh School of Medicine, 1915; aged 61; died April 27; member of the Ohio State Medical Association and a Fellow of the American Medical Association; vice-president of the Mahoning County Medical Society in 1940 and president in 1941; delegate to the Ohio State Medical Association, 1936-39; diplomate of the American Board of Otolaryngology; member of the American Academy of Ophthalmology and Otolaryngology; member of the Association for Research in Ophthalmology. Following completion of service during World War I, Dr. Walker began his practice in Youngstown. In addition to his medical career, he was active in numerous civic and fraternal activities; was a member of the Presbyterian Church, the Elks Club, the Youngstown Club, the Masonic Lodge, the Southside Merchants and Civic Association and Phi Rho Sigma. Surviving are his widow, two sons and two brothers.

John Peterson Young, M. D., Empire; Baltimore Medical College, 1894; aged 90; died April 8; former member of the Ohio State Medical Association and the American Medical Association through 1940. Dr. Young had practiced his profession in Jefferson County for more than 50 years. Recently he was honored by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. He was Jefferson County Health Commissioner from 1919 until 1940 when he retired from active practice. Other activities include memberships in the Methodist Church, the Masonic Lodge and the Knights of Pythias. Surviving are two sons, one of whom is Dr. John W. Young of Empire and Steubenville, and a sister.

Dr. Shaffer To Direct Workshop In School Health

The third annual School Health Education Workshop will be held on the Ohio State University campus, Columbus, for three weeks beginning on June 20. The workshop is designed for school physicians and nurses, school administrators and others interested in school health.

Special emphasis will be given to these considerations: health needs of school-age children; recognition of physically handicapped children; teacher-nurse-physician cooperation; understanding the worries of children; use of resources in teaching health; community participation in health activities of the school.

Further information may be obtained from: Dr. Thomas E. Shaffer, Workshop Director, Room 8, The University School, Ohio State University, Columbus 10, Ohio.

Four Members Are Reappointed On Hospital Advisory Council

Dr. John D. Porterfield, director of the Ohio Department of Health, announced reappointment for four-year terms of four members of the Hospital Advisory Council, whose terms had expired.

Those reappointed, all of whom have served since organization of the Advisory Council, are: Dr. George A. Woodhouse, Pleasant Hill; Mr. Charles S. Nelson, Columbus, Executive Secretary of the Ohio State Medical Association; Mr. W. L. Benfer, Superintendent of Toledo Hospital; and Mr. Artee Fleming, Akron attorney.

The Council acts in an advisory capacity to the Office of Hospital Facilities of the Ohio Department of Health which administers Federal grants-in-aid toward hospital construction under the Hill-Burton Law.

Dr. Porterfield is ex officio chairman of the Council. Judge John H. Lamneck, director of Public Welfare, is an ex officio member, and Anthony J. Borowski, Dr. P. H., administrator of the Office of Hospital Facilities, is its secretary.

Other members are: Dr. M. F. Steele, superintendent of Christ Hospital, Cincinnati; Mr. Robert M. Porter, administrator of Children's Hospital, Columbus; Mr. Guy J. Clark, executive secretary of the Cleveland Hospital Council; Monsignor Robert A. Maher, director of the department of health and hospitals for the Catholic diocese of Toledo; Mr. Charles F. Owsley, Youngstown architect; Miss Nell Robinson, superintendent of East Liverpool Hospital; Mrs. Frances Hoffman, Columbus Metropolitan Health Council; Mr. Harry W. Culbreth, Ohio Farm Bureau; Mr. Joseph W. Fichter, master of the Ohio State Grange; Dr. J. F. Bateman, director of the Columbus State Hospital; Dr. Ralph L. Rutledge, Alliance; and Dr. Joseph B. Stocklen, comptroller of Tuberculosis for Cuyahoga County.

Fort Steuben Academy

The Fort Steuben Academy of Medicine had as guest speaker at its April 11 meeting, Dr. Henry L. Bockus, University of Pennsylvania Graduate School of Medicine, who spoke on "Recent Advances in Treatment in the Field of Gastroenterology."

Dr. Joseph DeLor, Ohio State University College of Medicine, Columbus, opened discussion on the presentation. Dr. Carl A. Lincke, Carrollton, President of the Ohio State Medical Association, acted as chairman of the discussion.

Members of the Academy heard a talk by Dr. Thomas Francis, Jr., of the University of Michigan School of Public Health, on "The Control of Acute Respiratory Diseases," on March 14.

Ohio Supreme Court Rules Out Medical Texts in Evidence

The Ohio Supreme Court early in April held that medical books or treatises, even though properly identified and authenticated and shown to be recognized as standard authorities on the subjects to which they relate, are not admissible in evidence to prove the truth of the statements therein contained.

The ruling was made in the case of Hallworth v. Republic Steel Corporation. Hallworth suffered an injury while working for the appellant when a piece of metal struck him on the back of the neck, and possibly back of head, and died 20 days later of a cerebral hemorrhage.

The widow filed a claim for death benefits under the Workmen's Compensation Act, against the defendant, a self-insurer. The claim was disallowed by the Industrial Commission on original hearing and on rehearing.

An appeal was filed in the Common Pleas Court. The case was tried before a jury which returned a verdict for the plaintiff, the widow. The trial court granted motion for a new trial on the ground that the verdict was not sustained by sufficient evidence. The jury again returned a verdict for the plaintiff. The Common Pleas Court overruled defendant's motion for judgment and rendered judgment for the plaintiff on the verdict.

Defendant appealed to the Court of Appeals which affirmed the judgment of the Common Pleas Court.

In testimony before the jury in Common Pleas Court, the defendant's physician witness was cross-examined by plaintiff's counsel reading portions from the medical text. In regard to this examination, the Supreme Court opinion stated: "No objection was made by defendant to this cross-examination (of the witness), so that the question, as to whether such cross-examination was or was not proper, is not directly before the court in this case."

At the conclusion of the cross-examination, the Common Pleas Court accepted the text in evidence. This the Supreme Court found erroneous. The opinion in part read: ". . .Admission in evidence of such a book or treatise or any part thereof would, in effect, admit into evidence the testimony of the author of the book without affording to opposing counsel any opportunity to cross-examine him. Furthermore, the court would, in effect, be allowing the author to testify without having required him to take the usual oath required of a witness."

Dr. and Mrs. George Crile, Jr., Cleveland, presented their new all-color film, "The Underseas World," in the Masonic Auditorium, as part of "Round the World Adventure Series."



Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

ADAMS

At a luncheon meeting of the Adams County Medical Society on April 20, Dr. Elmer P. R. Maurer, Cincinnati, discussed "Carcinoma of the Lung." A business meeting preceded the luncheon and scientific program.

CLINTON

Dr. Anson L. Brown, Columbus, was guest speaker at the April 4 meeting of the Clinton County Medical Society. His discussion was based on a film shown to the group, "Papanicolaou Technique for Early Diagnosis of Cancer."

HAMILTON

Dr. Hilde Bruch, College of Physicians and Surgeons, Columbia University, spoke during a joint program of the Academy of Medicine of Cincinnati and the Nutrition Council of the Public Health Federation on April 4, on the subject, "The Psychology of Obesity." Her paper was discussed by Drs. Maurice Levine, Cecil Striker, Richard Wolf and Kurt Tschiassny.

"Factors in the Control of Bleeding" was the topic of a discussion by Walter H. Seegers, Ph. D., Wayne University College of Medicine, at the April 18 meeting of the Academy.

At the May 2 meeting, Dr. William F. Mengert, Southwestern Medical College, Dallas, Tex., spoke on the subject, "Management of Menstrual Irregularities."

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CLARK

Dr. C. W. Hullinger, Springfield, spoke on "Postural Backache" at the March 20 meeting of the Clark County Medical Society in the Ker-Deen Inn. On April 6 the regular business meeting of the Society was held in the same place.

Dr. Morton S. Bryer, Johns Hopkins University School of Medicine, Baltimore, spoke on the subject, "The Clinical Use of the Newer Antibiotics," at the April 24 meeting of the Society.

DARKE

"The Fenestration Operation for Deafness" was discussed by Dr. Robert E. Boswell, Dayton, at the April 18 meeting of the Darke County Medical Society in Greenville.

GREENE

The Greene County Medical Society and three other neighboring county medical societies sponsored a symposium and scientific meeting at the Fels Research Institute in Yellow Springs on April 19. Other sponsors of the meeting were the Clinton, Fayette and Highland County Medical Societies.

Speakers and subjects discussed included the following:

Dr. F. C. Ottati, Indianapolis, Ind., of the Eli Lilly & Co., "Newer Concepts of Antibiotics."

Dr. Nathan R. Abrams, University of Cincinnati College of Medicine, "Medical Aspects of Arthritis."

Dr. Robert Perlman, University of Cincinnati College of Medicine, "Management of Chronic Arthritis."

Dr. Richard Patton, Ohio State University College of Medicine, Columbus, "Diagnosis of Acute Abdomen."

Speaker of the evening session was Hon. Paul M. Herbert, former lieutenant governor of Ohio and former state commander of the American Legion, Department of Ohio.

The Greene County Medical Society is now publishing a printed bulletin. Editors are Dr. R. W. Barry and Dr. R. D. Hendrickson, president and secretary, respectively, of the Society. Mr. Frank C. Bateman, of Springfield, has been appointed executive secretary of the Society and is managing editor and business manager of the publication.

MONTGOMERY

Dr. Stanley E. Dorst, dean of the University of Cincinnati College of Medicine, was guest speaker at the May 12 meeting of the Montgomery County Medical Society at the Engineer's Club in Dayton. His discussion on the subject, "Medical Training in Great Britain Under the Program of Nationalized Health," was based on a recent visit in England which he made as a member of an A. M. A. committee to study health and medical services in that country.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D., UPPER SANDUSKY)

SENECA

Dr. Bert Seligman, Toledo, was speaker at the regular meeting of the Seneca County Medical Society on April 17 in Tiffin. His discussion was based on the differential diagnosis of lymphedema.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

LUCAS

The scientific program of the Academy of Medicine of Toledo and Lucas County for April included the following features:

Section on Pathology, Experimental Medicine

and Bacteriology, April 7 — "Acute Dilation of the Stomach," Dr. A. E. Rhoden; "Necrotizing Papillitis," Dr. M. F. Vidoli.

Postgraduate Program, April 14—"The Present Status of Anti-Coagulant Therapy," Dr. G. DeTakats, Chicago; "Paroxysmal Ventricular Tachycardia, Its Importance, Diagnosis and Management," Dr. G. K. Fenn, Chicago.

General Practice Section, April 18—"Office Urology," Dr. A. S. Avery, Toledo.

Medical Section,—"Electrophoretic Changes in Hemoglobin in Various Types of Anemia," Dr. G. Watson James, Richmond, Va.

The annual meeting of the Toledo Medical Library Association was held with a banquet at the Hillcrest Hotel on April 28. Dr. H. F. Howe was program chairman.

WOOD

The Wood County Medical Society held its regular dinner meeting at the Midway Restaurant, Perrysburg, on April 20. Dr. Raymond N. Whitehead presided.

This was a joint meeting with the Fourth District Chapter of the American Academy of General Practice.

Dr. Herman Mannhardt, President of the Academy, gave a short talk on the aims and work of that organization and introduced Dr. Wayland B. Recker, of Liepsic, past-president, who gave a short report on the St. Louis meeting and plans for the future. He said the Academy was growing very rapidly. The new magazine *GP* was shown and excited interest among those present.

Dr. George H. Lemon, of the Lucas County Chapter, talked on the Intern situation and introduced a resolution making for better distribution of Interns among University and non-university connected hospitals. The resolution was passed unanimously.

The paper of the evening was given by Dr. George Booth, Toledo, on "The Sciatic Syndrome; Its Diagnosis and Treatment." His talk was well illustrated with slides. The cause of the characteristic symptoms was discussed together with treatment.

This was an informative paper based largely on Dr. Booth's wide experience in neurosurgery. A rising vote of thanks was tendered Dr. Booth.

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

ASHTABULA

The Ashtabula County Medical Society met at Chapman's Diner at Geneva on April 11. Dr. C. T. Risley, Conneaut, president, was in charge. The former secretary, Dr. John B. Hall, of Geneva, read the minutes of the last meeting in the absence of the secretary.

The speaker of the evening was Dr. Arthur F. Young, Cleveland, whose subject was "Cor-



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onary Heart Disease." He discussed new methods of artery injections using radiopaque material to study postmortem specimens. He also discussed Sellensinger's group, maintaining that all coronary artery disease falls in these patterns. He maintained that 40 per cent appeared to be balanced, 40 per cent organized in the right artery and 20 per cent in the left artery. The speaker said that it is thought that the coronary pattern may follow the heredity pattern and that anemia may cause early coronary anastomosis. The speaker expressed definite value in anticoagulants. It was thought, he said, that Vitamin E had proven of little value in coronary heart disease.

CUYAHOGA

Miss Anna Freud, of London, England, daughter of Sigmund Freud, was guest speaker at the April 26 meeting of the Cleveland Academy of Medicine where she spoke on the psychological aspects of caring for children in hospitals. She was introduced by Dr. Douglas D. Bond, of the psychiatry department, Western Reserve University School of Medicine.

LAKE

Members of the Lake County Medical Society were guests on April 5 of the Industrial Rayon Corporation, at a dinner at the Painesville plant. Dr. John Rausch Kolb, Cleveland, was guest speaker on the topic, "Industrial Dermatoses." Dr. C. B. Elliott, Painesville, was responsible for program arrangements.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

COLUMBIANA

Fifty-year Pins and Certificates of the Ohio State Medical Association were presented to three members of the Columbiana County Medical Society at the April 18 meeting. Dr. Paul A. Davis, Akron, Councilor of the Sixth District, made the presentations.

Those who received the awards are Dr. H. J. Pelley, Hanoverton; Dr. W. A. McCommon, East Palestine; and Dr. A. B. Hobson, Salem.

Although Doctors McCommon and Hobson were unable to attend because of poor health, Dr. Pelley, still active and practicing at the age of 86, was present to receive the certificate and pin. Dr. Pelley stated that he is still "on call 24 hours a day, seven days a week, and intend to be as long as I am able." He received his M. D. degree from Western Pennsylvania Medical College, now the University of Pittsburgh Medical College, in 1892, and took his postgraduate training in the New York Polyclinic Hospital in 1901. He is an honorary staff member of the Salem Central Clinic Hospital. He is the only practicing physician in

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Hanoverton and the surrounding rural area, the Society secretary reported, because as Dr. Pelley stated, "the people still need me."

The scientific portion of the meeting was high lighted by an illustrated lecture on the "Present Management of Hypertensive Diseases," presented by Dr. Robert Taylor, of Cleveland.

PORTAGE

The heart revascularization operation developed by Dr. Claude S. Beck, of Cleveland, with the assistance of Dr. David S. Leighninger, was described by Dr. Leighninger at the April 13 meeting of the Portage County Medical Society in Ravenna.

SUMMIT

"The Challenge of Longevity" was the topic of a talk by Dr. Edward J. Stieglitz, Washington, D. C., at the May 2 meeting of the Summit County Medical Society in Akron.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

"The Use of Digitalis in Heart Failure," was the title of a film which was the basis of the scientific program of the Belmont County Medical Society on April 13 in the Martins Ferry Hospital. The program was presented by the hospital staff with Dr. H. H. Murphy, Society President, in charge.

Dr. Charles D. Hershey, of the Wheeling Clinic, spoke on "Peripheral Vascular Disorders" at the May 11 meeting of the Belmont County Medical Society at the Belmont Hills Country Club. Members of the Auxiliary were guests.

TUSCARAWAS

Dr. Phillip T. Doughten was accepted as a new member in the Tuscarawas County Medical Society at the April meeting. He is a graduate of Western Reserve University School of Medicine and served in the Air Forces as a captain from Sept., 1947, to 1949. He will practice from his office in New Philadelphia.

The secretary reported that Dr. John C. Blinn, who was severely injured in an auto accident February 13, was removed late in April from Union Hospital to his home in New Philadelphia.

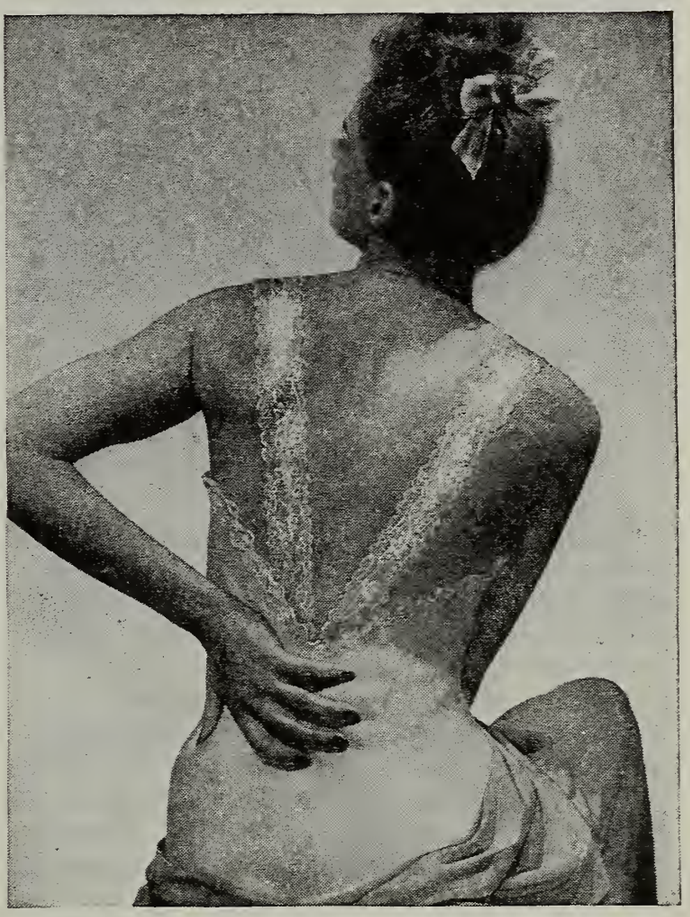
Eighth District

(COUNCILOR: CHESTER P. SWETT, M. D., LANCASTER)

MUSKINGUM

Dr. Kenneth H. Abbott and Dr. James R. Gay, both of Columbus, spoke on "Trauma of Head and Cervical Spine" at the April 5 meeting of

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PERRY

Six Perry County physicians have been honored, one of them posthumously by being awarded the 50-Year Pin and Certificate of the Ohio State Medical Association. Dr. Chester P. Swett, Lancaster, Councilor of the Eighth District of the Association, made the presentations. Those so honored by being presented the awards personally are Dr. James Miller, Corning; Dr. Harry W. Shaw, New Lexington; Dr. John F. Switzer, New Straitsville; Dr. Marcus O. Smith, New Straitsville, and Dr. Frank R. Clemson, Thornville. Dr. Swett presented the award to the widow and son of Dr. John G. McDougal, late of New Lexington.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

LAWRENCE

Nearly a hundred persons, including doctors, their wives and guests attended the Ninth District Conference held in Ironton on April 27. The Lawrence County Medical Society was host to the district conference.

A team of three physicians invited by the Cancer Committee of the Ohio State Medical Association presented the scientific program on the subject, "Cancer of the Uterus." Dr. Hans G. Schlumberger presented the subject from the standpoint of the pathologist; Dr. Joseph L. Morton spoke on radiological aspects; and Dr. Charles H. Hendricks gave the surgical aspects. The presentation was in the form of a panel discussion.

The Woman's Auxiliary to the Lawrence County Medical Society with Mrs. G. Newton Spears as president served tea for the ladies in the Elks parlors. Dr. Ralph F. Massie conducted the doctors on a tour of the new addition to the Lawrence County General Hospital. Dinner was served at the Episcopal Church parish house.

Following the dinner, Dr. Daniel J. Webster, Ironton, was presented the 50-Year Pin and Certificate of the Ohio State Medical Association by Dr. J. P. McAfee, Portsmouth, Ninth District Councilor.

Mr. George H. Saville, Columbus, public relations director for the Ohio State Medical Association, spoke on the subject, "Present Status of Medical Public Relations."

PIKE

Officers of the Pike County Medical Society for the year are Dr. C. L. Critchfield, Waverly, president; and Dr. Albert M. Shrader, Waverly, secretary. Dr. Critchfield was secretary for the

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preceding year and succeeds Dr. Charles A. Clifton, of Piketon, as president.

SCIOTO

Guest speaker at the April 10 meeting of the Hempstead Academy of Medicine was Dr. Robert J. Tapke, Cincinnati, whose topic was "Carcinoma of the Colon." A buffet lunch was served at the Nurses' Recreation Hall of General Hospital.

At the May 8 meeting of the Academy, Dr. Norman O. Rothermich, Ohio State University College of Medicine, Columbus, discussed the subject, "Further Treatment of Diabetes."

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

PICKAWAY

Pickaway County Medical Society honored three physicians, one posthumously, for a half century or more of practice by awarding them 50-Year Pins and Certificates of the Ohio State Medical Association. The dinner meeting was held on April 20.

Those so honored are Dr. George R. Gardner, Ashville; Dr. A. W. Holman, formerly of Circleville but now of Columbus; and the late Dr. Dudley V. Courtright whose award was presented to his son at the banquet.

Awards were presented by Mr. Charles S. Nelson, Columbus, Executive Secretary of the Association. Dr. Jasper M. Hedges was toastmaster for the occasion. Dr. Lloyd Jonnes spoke in praise of the honored doctors.

ROSS

Four Ross County physicians were honored, two of them posthumously, by the Ross County Medical Society. Dr. William L. Counts and Dr. O. P. Tatman, both of Chillicothe, were presented the 50-Year Pin and Certificate of the Ohio State Medical Association. The same awards were presented to the widows of the late Dr. Charles C. Hatfield, Kingston, and the late Dr. O. L. Iden, of Chillicothe. Dr. Ralph W. Holmes, Dr. Loy E. Hoyt and Dr.



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Albert E. Merkle, representing the Ross County Medical Society, made the presentations.

Eleventh District

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LORAIN

Dr. Robert W. Heinle, Cleveland, spoke on "The Anemias" at the April 4 meeting of the Lorain County Medical Society. Dr. Swen D. Nielson, president, presided at a business meeting following the scientific program.

The Postgraduate Symposium conducted by a team from the University of Illinois College of Medicine, and presented by the Lorain County Medical Society drew more than 70 doctors to the Spring Valley Country Club, Elyria, on April 26.

The guest doctors and their subjects were: Dr. Max M. Montgomery, "Present Status of Antibiotic Therapy"; Dr. William Requarth, "Surgical Therapy of Pancreatic Disease"; Dr. Louis R. Limarzi, "Present Status of Therapy of Hematological Diseases"; Dr. Edmund F. Foley, "Jaundice"; and Dr. Willard O. Thompson, "Treatment of Thyrotoxicosis."

Following dinner, Dr. Thompson again addressed the group on the subject, "Clinical Applications of Cortisone and ACTH." Dr. Nielsen presided at the meeting.

RICHLAND

Members of the Richland County Medical Society and the medical staff of the Mansfield General Hospital held a combined meeting at the hospital on April 27. Dinner was followed by a business meeting and scientific program.

Speaker on this occasion was Dr. H. Keith Fischer, Philadelphia, Pa., who spoke by arrangement with the Ohio State Mental Hygiene Association, on the subject, "Psychiatric Basis for General Medicine."

Special Instructional Course On "Complications Of Anesthesia"

"Complications of Anesthesia" is the subject of an Instructional Course sponsored by the Ohio Society of Anesthesiologists. It will be held at the University Hospital in Columbus on Saturday, June 24, 1950. A clinical session will start at 8:00 a. m., and a number of anesthetic techniques will be demonstrated. This will be followed by a luncheon at the Faculty Club. The afternoon session will begin at 1:30 and will be devoted to discussions on anesthetic complications. The physiologic mechanisms and the influence of drugs, methods and coincidental disease will be stressed. There is no registration fee, and all physicians interested in anesthesia are invited to attend.

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OHIO DOCTOR'S WIFE HONORED

Mrs. William F. Marting of Ironton—a member of the Woman's Auxiliary to the Lawrence County Medical Society—was signally honored this year being named the Ohio Mother for 1950.

In addition to being the wife of a doctor, Mrs. Marting, seventy-seven years old, is the mother of three doctors—Dr. Anne D. Alstott of Ironton, Dr. Miriam R. Marting of Ironton, and Dr. Esther Marting Fabing of Cincinnati. Mrs. Marting is prominent in club, civic, church, and community projects. She was given the award by the Woman's Forum of Cleveland which sponsored the state-wide competition. The judges who made the selection included three Cleveland newspaper editors, a judge of the municipal court and the general secretary of the Cleveland Y. M. C. A.

AUGLAIZE

The Auxiliary to the Auglaize County Medical Society met at the home of Mrs. E. F. Heffner on Wednesday evening, April 19. Mrs. Karl Kohler spoke on "The School Health Program."

BUTLER

"Socialization of medicine is the first planned step to make the United States a socialist nation," Dr. E. O. Swartz, president-elect of the Ohio State Medical Association, told members of the Butler County Auxiliary at a luncheon meeting on April 25 at the Manchester Hotel. Dr. Swartz urged the auxiliary members to help in educating the public to the dangers of the program.

"The Job We Have to Do" was the theme of Dr. Swartz's talk. Annual election of officers also featured the April meeting at which Mrs. William Neel of Middletown was chosen president-elect. Mrs. Paul Ivans becomes the new president, succeeding Mrs. W. H. Henry. Other officers elected included: Mrs. William Jacobs, vice-president; Mrs. C. J. Chamberlain, corresponding secretary; Mrs. Ralph Leyer, recording secretary; Mrs. Robert Wilson, treasurer; and Mrs. Kenneth Smith, director.

Mrs. Neel was chairman of arrangements for the meeting and was assisted by Mrs. Martin Decker, Mrs. Thomas Wenzel, Mrs. C. T. Atkinson and Mrs. Smith.

DELAWARE

Mrs. A. R. Callander was elected president of the Delaware County Auxiliary at its luncheon meeting held on April 25. Mrs. Wray Davies is president-elect; Mrs. George Parker, vice-president; Mrs. G. T. Blydenburgh, secretary, and Mrs. W. W. Livingston, treasurer. Mrs. Harold W. Davis of Ashley, the outgoing president, was hostess at the luncheon.

ERIE

Members of the Woman's Auxiliary to the Erie County Medical Society entertained their husbands with a dinner party at the Plum Brook Country Club on April 29. Mrs. E. J. Meckstroth was chairman of the arrangements committee.

FRANKLIN

The April meeting of the Woman's Auxiliary to the Columbus Academy of Medicine was held at the home of Mrs. Howard E. Boucher. The program committee presented a light comedy "Girls Must Talk," the cast of which was made up of auxiliary members. Mrs. Harley Thomas, harpist, provided the afternoon's musical program.

Mrs. K. D. Reichelderfer was chairman of hostesses, with Mrs. Karl P. Klassen and Mrs. Thomas E. Fox as co-chairmen. They were assisted by Mrs. Thurman R. Fletcher and Mrs. Clyde W. Dawson, members of the music committee.

HAMILTON

The Hamilton County Auxiliary presented Dr. Esther Marting Fabing as its guest speaker at the organization's meeting on April 18 at the home of Mrs. Paul Hoxworth. Dr. Marting Fabing's talk was on "What's Being Done About Cancer" and she was introduced by Mrs. Lloyd Larrick, program chairman.

The meeting's business agenda included the annual election of officers. Those elected include: Mrs. Richard Vilter, president-elect; Mrs. Robert Kotte, vice-president; Mrs. Herbert Brinker, recording secretary; Mrs. Walter Engel, corresponding secretary; Mrs. Warren Strohmenger, treasurer; and Mrs. Paul Woodward, director for a two-year term.

At the tea which concluded the afternoon's program, Mrs. V. E. Siler, hospitality chairman, was assisted by Mrs. Charles A. DeWert, Mrs. Joseph Goldcamp, Mrs. John Fleming and Mrs. Harold Humphrey.

HARDIN

The Woman's Auxiliary to the Hardin County Medical Society held its March meeting at San Antonio Hospital. Sister Adelaide of the hospital staff gave a brief talk and thanked the organization for the money donated to the hospital from the Mistletoe Ball. Mrs. Robert Ruffing gave an interesting talk on "Hat Designing." Mrs. Albert Sage, president, conducted the business session.

LAWRENCE

The Elks Club parlors was the scene of a tea and meeting on April 27 when the Woman's Auxiliary to the Lawrence County Medical So-

ciety entertained the doctors' wives of the Ninth District. This meeting was held concurrently with that of the doctors attending the Ninth Medical District Session. The get-together convened at one o'clock when members and guests were registered by Mrs. Forest Stewart, Mrs. Paul Baker and Mrs. Halsey Wheeler.

Mrs. G. N. Spears, Lawrence County president, presided at the business meeting and welcomed the guests. She introduced Mrs. C. W. Kirkland, state president, who spoke on state activities and the many accomplishments of Ohio's sixty organized counties. Another speaker on the afternoon's program was Mrs. W. E. Gault of Portsmouth who presented an outstanding book review on "The Elephant Walk."

Silver candelabra holding yellow tapers graced the center of the tea table, and Spring flowers in artistic arrangement added to the decoration. Mrs. Spears and Mrs. W. F. Marting presided at the table. Later in the afternoon, many of the women joined the delegation that went on tour of the new addition at Lawrence County General Hospital. The women joined their husbands for the dinner held at six o'clock at the Episcopal parish house.

LICKING

Twenty-five members of the Auxiliary to the Licking County Medical Society assembled on April 25 at the Moundbuilders Country Club for a dinner meeting. The program for the evening featured a book review by Mrs. Norton Suter on "The Plum Tree" by Mary Ellen Chase.

Mrs. J. Y. Salzman, retiring president, presented the gavel to the incoming president, Mrs. Roland Jones, who announced her committee appointments for the year.

Plans were made for the rummage sale to be given for the benefit of the hospital on May 13.

LOGAN

The Logan County Auxiliary met on April 25 for its regular monthly meeting at the home of Mrs. John Maurer. Mrs. F. B. Webster, president, presided at the business session. An interesting book review on "The Physician's Wife" was given by Mrs. A. J. McCracken as the

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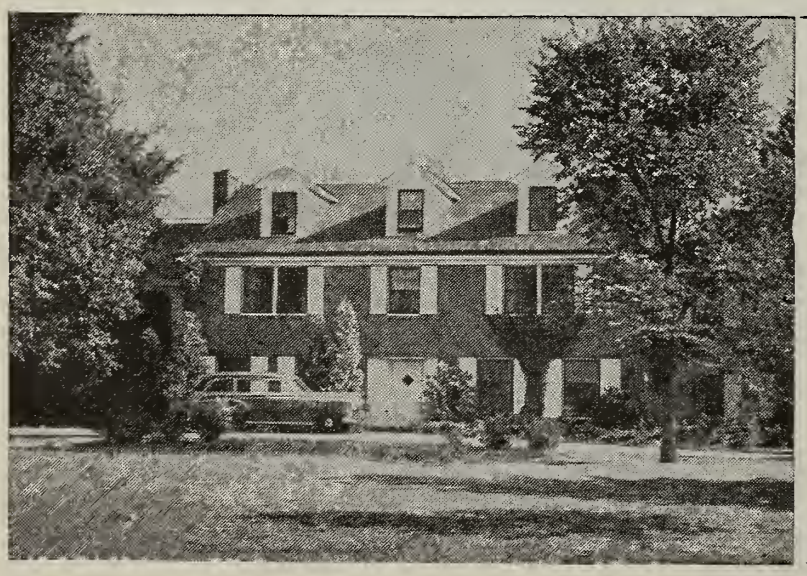
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afternoon's program feature. A social hour with refreshments followed.

LORAIN

Miss Eleanor Goldstein, case worker with the Lorain County Guidance Center, was guest speaker at the March luncheon meeting of the Lorain County Auxiliary. Mrs. Theodore Berg, vice-president, presided at the business session in the absence of the president, Mrs. L. B. Stephan. A nominating committee was named to present a slate of officers at the May meeting.

Shamrocks, daisies and green tapers formed the centerpiece for the luncheon table, with miniature shamrocks at each place.

In her talk on mental hygiene, Miss Goldstein explained the types of mental illness and how the state of Ohio cares for its mental patients. She then traced the development of the Lorain County Center and stressed the importance of its work.

LUCAS

A benefit luncheon and card party was held by the Woman's Auxiliary to the Toledo and Lucas County Academy of Medicine on April 25 to raise funds for the new Academy building. Approximately 450 people were present. Many prizes, good food and a pleasurable social hour made it more than just a money-making project. Mrs. Hauzen Hauman and Mrs. Joseph Hertzberg who head the Fund Raising Committee were in charge of arrangements.

At the March luncheon meeting of the Auxiliary, Dr. E. A. Ockuly, president of the Toledo Academy of Medicine, gave a stimulating talk on "Present Trends in Medical Legislation."

The regular April meeting of the group was an "Open Tea" on April 18 and featured Rabbi Leon I. Feuer who spoke on "Peace Through World Health."

The two study group programs continue active participation, meeting each month.

MAHONING

Dr. R. L. Rutledge, a past-president of the Ohio State Medical Association, spoke to the members of the Mahoning County Auxiliary at its April meeting at the Woman's City Club in Youngstown.

MARION

Luncheon was followed by a program and brief business session when the Woman's Auxiliary to the Marion Academy of Medicine held its March meeting at Hotel Harding. Mrs. Joan Reams entertained with a musical sketch.

On April 15, the regular monthly luncheon meeting was in the form of a "guest party" and featured as its speaker, Miss Carolyn Bradley, a member of the faculty at Ohio State University. Author, painter and lecturer, Miss Bradley showed paintings and costumes and described countries visited on her recent trip to Central America. Completing the program was a group

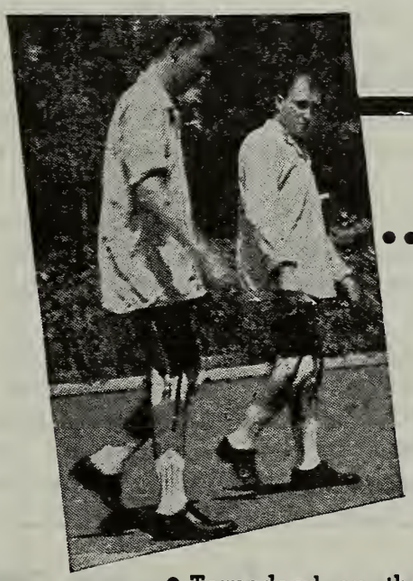
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of musical selections by Mrs. Reams. Mrs. B. H. Taylor, vice-president, presided.

MEIGS

Mrs. J. J. Davis was hostess at a dinner meeting of the newly organized Meigs County Auxiliary in March. For the April meeting the group entertained with a luncheon held at Little House, the hostess, Mrs. Selim Blazewicz. Mrs. E. F. Maag, president, conducted the business session.

MONTGOMERY

The Montgomery County Auxiliary held a luncheon meeting on April 11 at the Engineers' Club. Fifty members were present. Installation of officers was conducted by Mrs. Paul Woodward, state vice-president. A panel discussion on Socialized Medicine was presented by Mrs. David W. Heusinkveld, Mrs. Charles Baron and Mrs. Woodward, guests from the Hamilton County Auxiliary. Chairman in charge of arrangements for the day was Mrs. S. N. Maimon.

The newly installed officers include: Mrs. Robert Zipf, president; Mrs. H. M. James, president-elect; Mrs. E. W. Smith, vice-president; Mrs. J. J. Shea, recording secretary; Mrs. Irving Helfert, corresponding secretary; Mrs. R. H. Caplan, treasurer.

OTTAWA

Members of the Woman's Auxiliary to the Ottawa County Medical Society were hostesses on April 19 at a tea at Magruder Hospital at which forty-five junior and senior girls from Oak Harbor, Lakeside and Port Clinton high schools were guests. These girls had previously indicated an interest in following nursing as a career.

The girls assembled in the solarium where they were welcomed by Mrs. W. R. Gibson, auxiliary president. Then, in groups of ten, they were taken on a complete tour of the hospital by Superintendent Rachel Garlich and Miss Esther Fullwiller, first floor supervisor. Miss Garlich distributed booklets concerning nursing as a career, and answered questions. A social hour followed, with refreshments served in the hospital dining room. Presiding at the tea table were Mrs. Gibson and Mrs. C. R. Wood, district director.

PICKAWAY

Eighty-three girls from Circleville and, Ashville were guests of the Pickaway County Auxiliary on a tour of Mt. Carmel Hospital in Columbus on April 14. The trip, sponsored by the auxiliary, was offered to those interested in choosing nursing as a career.

ROSS

Installation of new officers followed the dinner meeting on May 4th of the Ross County Auxiliary at Allyn's dining room. Mrs. F.

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W. Nusbaum, outgoing president, installed the new officers. They are:

Mrs. Walter E. Kramer, president; Mrs. L. T. Franklin, vice-president; Mrs. Nicholas Holmes, secretary; and Mrs. Robert Giesler, treasurer. Committee chairmen appointed by Mrs. Kramer include: membership and radio, Mrs. L. T. Franklin; program, Mrs. R. C. Bane; publicity, Mrs. John Franklin, historian, Mrs. Warde Smith; ways and means, Mrs. Walter Breth; legislative and public relations, Mrs. William Garrett; bulletin and handbook, Mrs. Robert Swank; student nurses' loan fund, Mrs. Wood. Mrs. Kramer announced that the nurses' loan fund is available to any Ross County student who needs financial help for her nurse's training.

SANDUSKY

Mrs. A. F. Schultz was named new president of the Sandusky County Auxiliary at its dinner meeting on March 15. Other officials elected to office at that meeting included Mrs. Francis A. Visconti, vice-president; Mrs. Richard Wilson, secretary and Mrs. C. L. Kuntz, treasurer. Mrs. Robert Fox, the outgoing president, opened the meeting and presented the new officers.

On April 19, members of the Auxiliary were hostesses at a benefit dessert-bridge at the Nurses' Home at Memorial Hospital. Those in charge of arrangements were Mrs. John Manahan, chairman, Mrs. E. C. Swint, Mrs. A. P. Newman, Mrs. Irvin Koons, Mrs. Richard Wilson, Mrs. W. J. Martin and Mrs. Carroll Miller. Proceeds will be used to purchase needed equipment at the Nurses' Home.

SCIOTO

Installation of new officers marked the May 10 session of the Scioto County Auxiliary when the organization gathered at the Turkey Shoppe for a luncheon meeting. Mrs. Clyde Everett is the group's new president. Serving with her are Mrs. Carter L. Pitcher, president-elect; Mrs. Carl G. Braunlin, vice-president; Mrs. Spencer K. Miller, secretary; Mrs. Ralph Lewis, treasurer, and Mrs. W. E. Gault and Mrs. Dow Allard, directors. Another feature of the afternoon was a "bed-clothing shower" for the Scioto County Home for the Aged.

Spring flowers in pastel hues decorated the tables with corsages for each guest. Mrs. Gault interestingly reviewed "Camp Fires on the Scioto" by Charles S. Wood.

At a short business meeting preceding the installation, presided over by Mrs. W. A. Ray, outgoing president, annual reports were made and the auxiliary project for the year, the raising of a fund to educate a young woman in nursing, was completed. Mrs. Everett appointed her new committee chairmen for the year.

Hostesses for the afternoon included Mrs. C. W. Wendelken, chairman; Mrs. R. P. Elder, Mrs.

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GYNECOLOGY—Intensive Course, 2 weeks, starting June 19, Sept. 25. Vaginal Approach to Pelvic Surgery, 1 week, starting Sept. 18.

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STARK

Mrs. A. E. Boyles was named president-elect of the Stark County Auxiliary at its annual election of officers held in April at the Alliance Woman's Club. The new president for the 1950-1951 year is Mrs. George Wilcoxon, who succeeded Mrs. Mark Herbst. Other officers elected include: Mrs. R. L. Rutledege, vice-president; Mrs. L. B. Schumaker, recording secretary; Mrs. M. E. Stillwell, corresponding secretary and Mrs. William R. Ferraro, treasurer.

TRUMBULL

The Trumbull County Auxiliary met on April 21 at the Warner Hotel for luncheon, celebrating its tenth anniversary and also honoring its past presidents—Mrs. W. G. Drown, Mrs. E. R. Westbrook, Mrs. D. R. Beers, Mrs. J. M. Gledhill, Mrs. A. L. Sparks and Mrs. Densmore Thomas. Mrs. C. W. Kirkland, state president, interestingly addressed the group.

Mrs. B. E. Goodman described the work of the Y. W. C. A., told of its aims and stressed the need of funds to repair the "Y" building. Mrs. Robert Held showed slides of pictures taken on a recent tour of the United States.

The new Trumbull County officers are: Mrs. A. W. Beale, president; Mrs. M. T. Knappenberger, president-elect; Mrs. Louis Ralston, vice-president; Mrs. John LaVoo, recording secretary; Mrs. Garner Scullard, corresponding secretary; Mrs. C. W. Mathias, treasurer; Mrs. D. R. Mathie, parliamentarian.

TUSCARAWAS

Mrs. William Hudson and Mrs. M. W. Everhard were appointed to represent the Tuscarawas County Auxiliary at the annual state auxiliary convention in Cleveland, being named April 12 when the group met at the home of Mrs. W. W. H. Curtiss. The constitution and by-laws were read and Mrs. H. F. Van Epps and Mrs. C. J. Miller appointed to make proposed changes. A social hour and refreshments followed the business session.

WILLIAMS

The Williams County Auxiliary held a luncheon meeting on April 11 at the Hotel Elder. Later the members were invited to the home of Mrs. John Diesen for an enjoyable social hour.

COMING MEETINGS

American Medical Association, Annual Session, San Francisco, June 26-30.

American College of Radiology, San Francisco, Calif., June 25.

Conference of County Medical Society Officers, San Francisco, June 25.

Eighth Councilor District Annual Meeting, McConnelsville, June 15.

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College Health Directors Hold Meeting at Kent

The 26th annual meeting of the Ohio College Health Association was held at Kent State University on May 5 and 6. Dr. A. O. DeWeese, director of student health services at Kent was host to the group and conducted visitors on a tour of the year-old Kent State model health center.

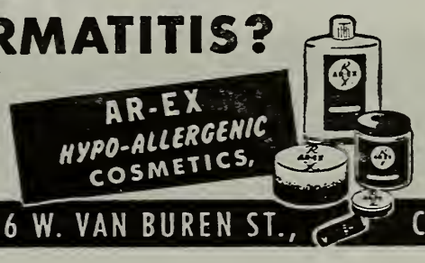
Among those on the program as moderators of discussion sessions were Dr. J. W. Wilce, Columbus, Ohio State University student health director; Dr. F. P. Bennett, Mt. Union College health service director; and Dr. Myrtle V. C. Dineen, Kent State resident physician.

Featured speaker at the banquet session was Dr. Marion S. DeWeese, University of Michigan Medical School, who discussed "The Relation of Warts and Moles to Cancer." He is a son of Dr. DeWeese of Kent State.



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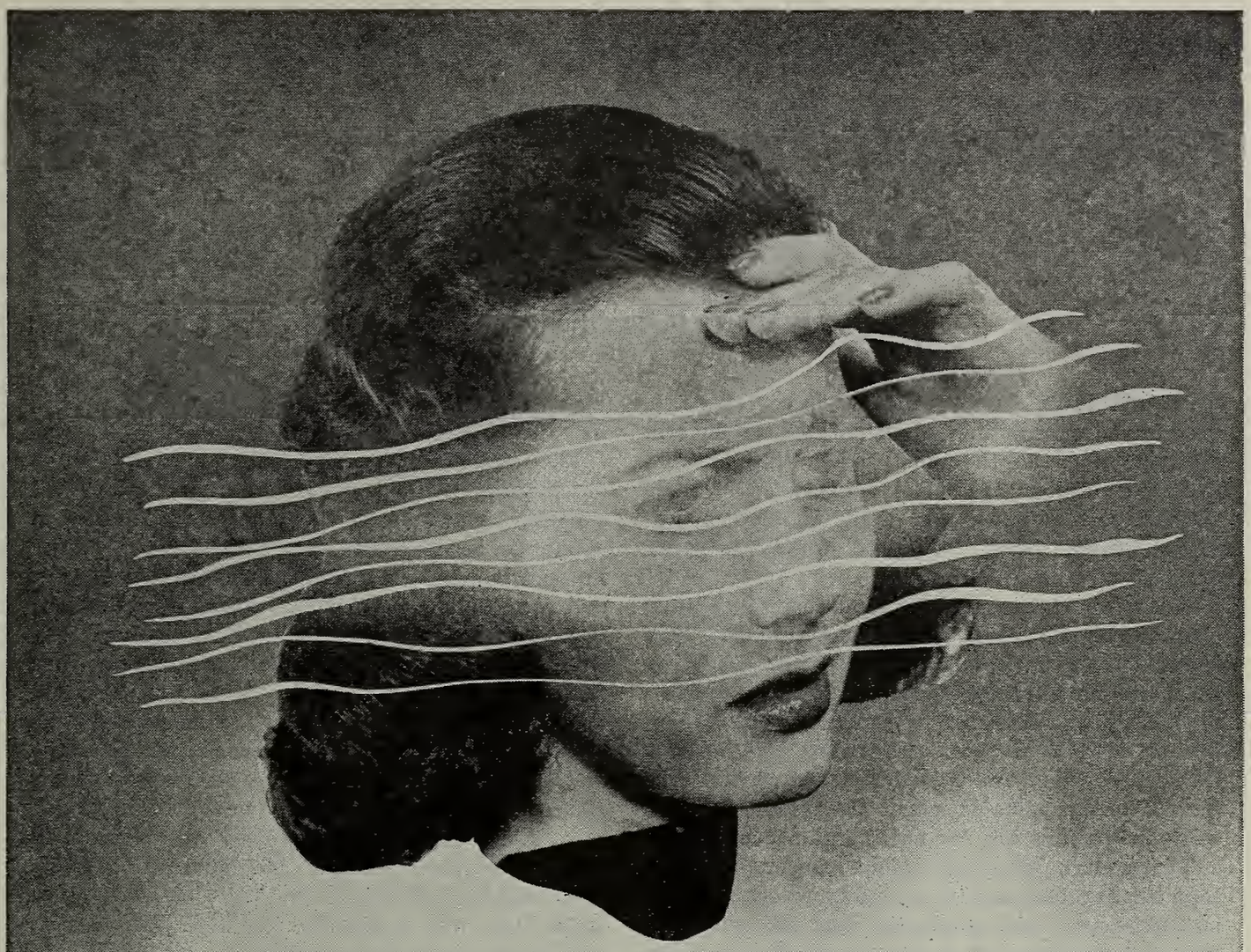
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Sex Education

IN RECENT months, there have appeared many books on the subject of sex which still appears to be the most fascinating of subjects. The books are widely diversified in their intent, their content, and their manner of approach—from heavy scientific tomes to pure pornography.

We might begin with a study of sexes in a changing world, **Male and Female** ($5.00. *William Morrow & Company, New York City)*, by Margaret Mead of the American Museum of Natural History. Many of us remember her "Coming of Age in Samoa," "Growing Up in New Guinea" or "Sex and Temperament." This well-known anthropologist spent 14 years in field work in preparation for writing this book.

The modern literature would lead one to think that all nervous tension arose from sexual maladjustments. Any physician can tell you that this is a problem of ecology, and Man and his disease are the resultant of millions of forces. The problem of sex is but one of many requiring straight thinking and proper attitudes toward life in general. It is these things that condition us for failure in marriage as well as in our work.

In **Be Your Real Self,** by David Harold Fink, M. D., ($2.95. *Simon and Schuster, 1230 Sixth Ave., New York City)*, the author has given us another book even better than his "Release From Tension." You will find this book of immense value in your attempts at reorientation of your patients. Working from this viewpoint sex comes to take a much more important place in the lives of your patients. If you can get your patients to make better use of time, space, things, and people they will come to have a proper place to put sex and it will come to have a richer meaning for them even though they have much less time to be concerned about it.

Every one of us who is interested, as every physician must be every day that he practices, with over-domestication of the male and the miseducation of the female under the misapprehension that equality means sameness, will want this book in his library. I look upon whatever problems sex raises in our changing society as but another expression of the utter failure of our educational system to teach us how to master the machine age. To anyone who is at all interested in pursuing this thought further, I would recommend Ralph Borsodi's opus magnum, **Education and Living** ($5.00. *Devin-Adair Co., New York City).*

The rise of the neutralized woman is an outstanding feature of our American mechanical culture. Amongst all the present-day confusion about sex equality the fact stands out as Ralph Borsodi insists that the sexes are complementary and cannot take each other's place either in the home or in industry. The new individuality which the feminist movement in America has produced is still best expressed in marriage and the family. For a study of the growth of this personality with its new concepts of marriage and attitudes towards divorce, the woman's new position in the family and the new problem which the change raises are explored successfully in **The American Woman in Marriage** ($3.75. *Philosophical Library, New York City)*, by Sonya Ruth Das, who comes to the task with a rich and cosmopolitan background.

These changes demand the elimination of fear and superstition from our sex lives and the development of more realistic patterns for finding and conserving happiness in marriage. Today the conservation of happiness is the great need. It is when the children are grown that in most marriages today happiness is lost. **Modern Pattern for Marriage**—The Newer Understanding of Married Love ($2.25. *Rinehart & Company, New York City)*, by Walter R. Stokes, M. D., attempts to guide young people in such a way that these values can be conserved.

There comes from the Mount Sinai Hospital and Vassar College a guide to happy marriage in the form of questions and answers as raised by GIs in the European Theatre, **Sex, Questions and Answers** by Fred Brown and Rudolf T. Kempton, ($2.95 *Whittlesey House, 330 West 42nd Street, New York City).* This book emphasizes that in Man, sex conduct is governed largely by external group and cultural forces and sex function is largely a learned process. As in everything else, our educational system does little or nothing to teach our youth how to live within the biologic norm. So much of today's sex learning is inaccurate and faulty. It is, however, a good sign that so many people are looking for facts and guidance as is indicated by the experience of these authors and by the great number of attempts to meet this need as shown in this review.

After years of inertia following one war

and preceding another, our knowledge of sex has been definitely increased. This, most would call progress. Be that as it may, the natural methods of Birth Control have been more clearly defined. In the present edition of their book, **The Illustrated Encyclopedia of Sex,** ($4.95. *Garden City Pub. Co., Garden City, N. Y.),* Drs. Willy, Vander, and Fisher give this first place. During recent years also the intrinsically great investigations of Steinach and Voronoff have failed as methods of rejuvenation. On the other hand, it has been established by proper hygiene and diet the vigor of the sexual apparatus and organism can be maintained far into old age. This appears to depend largely upon the general aging processes. It is therefore, only another phase of "Keeping one's health."

Much space is devoted by these authors to the activity of the endocrine glands in relation to sex. Here many a reader will learn for the first time about the nature and effects of feminine insensibility and may perhaps find the solution of many a mystery that has heretofore darkened his or her life. The illustrations in this English work prove most helpful.

Man's development and behavior from the zoological viewpoint is closely bound up with sex. It is, therefore, stupid for us to ignore our zoological heritage. James G. Needham, emeritus professor of entomology in Cornell, has given us a summary of this heritage in **About Ourselves** *(Ronald Press, New York City).* The first part of his book is concerned with the biological aspect of man and then in the second part, the author considers society in its biological aspects.

Today, we are concerned with population upsurge, **The Population Upsurge in the United States,** by Joseph S. Davis, ($1.00. *Food Research Institute, Stanford University, Stanford, Calif.).* This is largely a matter of breeding and feeding. So sex does become of great importance.

The subject of family life is important enough that all should have instruction in it. Based upon years of teaching, Robert A. Harper of the Department of Sociology in the Ohio State University, has written a text, **Marriage** ($2.70. *Appleton-Century-Crofts, Inc., New York City),* which fits well into the practical preparation for marriage type of course or study.

"Wives are young men's mistresses; companions for the middle-aged; and old men's nurses," was one of Francis Bacon's wise sayings of marriage. John Buncle, Jr., has prepared a manual entitled **Of Wives and Wiving** *(Henry Regnery Co., Chicago),* of instruction, exhortation and admonition gathered from older authors for the guidance, delight, and moral fortification of contemporary readers. This little volume of quotations is a delightful addition to any library.

"Read your insurance policy before you sign," is the way Father Liederbach begins his book of instruction and marriage counseling. **When a Catholic Marries** by C. A. Liederbach (50 cents. *The Bruce Publishing Company, Milwaukee, Wisc.)* assembles in a few pages instruction for those who will soon marry—Catholic and non-Catholic alike.

Since marriage is a sacred institution designed for the production and rearing of a family, the fertility, or the lack of it, becomes of major concern in any discussion of this subject. Th. H. van de Velde, M. D., the distinguished authority, has dedicated the third volume of his triology to the subject, **Fertility and Sterility in Marriage** ($7.50. *Random House, New York City).* The author gives one great guiding principle in the field of behavior:

> "The expert mastery of the physical aspects of sex must not become an end in itself—for otherwise the elusive ecstasy and permanent happiness alike are forfeited; it remains only a just and necessary human demand which mistakes do not nullify."

Every mother plans on having the perfect child but does not know how to go about it. A persuasive new book on this subject is **How To Create the Perfect Baby,** by R. Swinburne Clymer, M. D. ($2.50. *Philosophical Publishing Co., Beverly Hall, Quakertown, Pennsylvania).* This volume introduces the Art of Stripiculture. This art takes on a scientific turn after a 100 pages of instructions on how to plan and wish for beautiful features, great integrity, and desirable qualities. The next 50 pages cover the role of calcium, iodine, thyroid, phosphorus, iron, vitamin P and C. An interesting cult threading many scientific facts and beliefs into a new pattern which can do nothing but good to the woman at the breeding stage who wants to create the perfect baby.

The story of how life begins and goes on has been depicted on an educational film and now it has been condensed into a book, **Human Growth,** by Lester F. Beck ($2.00. *Harcourt, Brace & Co., New York City).*

In March, 1945, Leonard H. Biskind of Mount Sinai Hospital in Cleveland, Ohio, published in *The Journal* a series of answers to questions in regard to pregnancy and labor. This list has been extended and republished in *Modern Medicine* and in *The Western Journal of Surgery* and finally in book form, **Having Your Baby** ($2.50. *Western Journal of Surgery Publishing Co., Portland, Oregon).* As the book now stands it is a series of practical instruction in regard to pregnancy based upon the most modern concepts of prenatal care, the conduct of labor and delivery, and the course of the puerperium. A most valuable book for the expectant mother.

So much of the material put out for sex education became pornographic that it is a real pleasure to come across a book which has cut

loose from the past and tells all in a straightforward, clearly understandable manner in just 120 pages. **Sex Without Fear,** by S. A. Lewin, M. D., and Sarah K. Greenberg, M. D., with illustrations by John Gilmore, Ph. D. ($3.00. *Lear Publishers, Inc., 105 E. 15th St., New York City),* is intended as an aid in practice and covers every aspect of sex and sex relationships from genital anatomy to methods of contraconception. The publishers have initiated a new policy in that they are offering physicians discounts up to 50 per cent to enable them to keep sufficient copies on hand to meet the needs of their practice.

The book is beautifully designed and attractively illustrated by John Gilmore, the former art editor of *Clinical Symposia.* Dr. Lewin is a well-known author in the field of lay health education.

Somewhere in the Nineteenth Century, literary criticism became obsessed with the function of passing judgment on the merits of poetry and poets. In recent years, interpretative criticism has appeared. Roy Basler has given us a Freudian interpretation of Coleridge's "Christabel," Tennyson's "Maud," Poe's "Ligeia," Eliot's "Prufrock," in his book, **Sex, Symbolism and Psychology in Literature** ($3.50. *Rutgers University Press, New Brunswick, New Jersey).*

The close relationship between organized religions and symbolism gives us an interest in Pierre Gordon's **Sex and Religion** ($5.00. *Social Sciences Publishers, New York City),* in which he collects and coordinates certain ideas scattered throughout the literature of the ages, and uses these to solve other problems such as incest.

SEX IN CHILDHOOD

For dealing with children who have the problem of adjusting themselves to the various phases of the maturation of the sexual urge in its physical sense, there is a marvelous chapter on "physical expression of the sexual urge" in **The Envelope—A Study of the Impact of the World Upon the Child** ($3.00. *The Commonwealth Fund, New York City).* James S. Plant, M. D., has brought to bear his vast experience in dealing with problem and delinquent youngsters and the problem of making satisfactory adjustments to intense response arising from sexual stimulation and the fact that "raw" unsublimated expressions of sexual hunger are not acceptable to society. There are few persons, indeed, who strike a comfortable balance between these two sets of demands. Dr. Plant makes a distinction not often emphasized, the physical side of the sexual urge and the language values of sexual expression.

While citing many obstacles and failures, Dr. Plant sums up this matter as follows: "Society is so anxious that the physical urge be sublimated into socially useful activities that it bends its every energy towards the frustration of the actual physical expression, hoping to divert that energy to other channels. And at that it does a pretty efficient job."

Certainly, the language component looms large in the sex urge. Sex expression becomes a mode of communication for which they lack words. It leads the adolescent to feel he is grown, that she is wanted for herself, that both are "better," more popular than others. This book if you will read it will serve as an antedote for much of the current writings on sex in youngsters.

In the guiding of the child's development, we need standards and in Dr. Plant's brilliant work you will find excellent guideposts in matters of sex. Dr. W. W. Bauer of the A. M. A. Headquarters, working with Gladys Gardner Jenkins and Helen Shacter, has produced a general guide to their development and instructions on how to help them in the painful process of growing up, in **These are Your Children** ($3.50. *Scott, Foresman & Co., Chicago).* The book places its emphasis on three fundamental truths, i. e., (1) there is an infinite variation upon a basic sameness that is found in all of our children; (2) growth is a continuous process; and (3) the tremendous influence of a child's first years. The book contains suggestions for sex education at each age level.

Another book devoted exclusively to setting up guideposts for parents, sex educators and family counselors is **The Normal Sex Interest of Children,** by Frances Bruce Strain ($2.75. *Appleton-Century-Crofts, Inc., New York City).* This book is not a dry tome of documentary research but a lively handful of observations. It does, however, attempt to lift the man of ignorance and uncertainity in the belief that this will make him more normal and therefore happier.

Presenting the analytic side of this problem and quite in contrast to Dr. Plant's excellent exposition is **Children in Conflict,** by Madeleine L. Rambert ($3.25. *International Universities Press, Inc., New York City).* This is a report on twelve years of psychoanalytical practice. Mlle. Rambert has to offer an original innovation, a technique of her own, in the form of puppet games of such a kind that it allows each youngster to unfold his personality to the gaze of the analysts.

Teachers, leaders, parents, and other adults who are related to girls in the period of adolescence often have a hard time understanding them. From her work in the Y. W. C. A., Grace Loucks Elliott has written a book entitled **Understanding the Adolescent Girl** ($2.00. *Woman's Press, New York City).* It is simply the story of maturation of a normal girl, her problem and how her elders can help.

The problems of sex in European children are

somewhat different, at least in our minds. The fact is, however, that the French middle class is as beset by the harassing problems of sex education as we are over here. In England, the boarding schools accentuate this problem. Sex education in the school becomes a matter of the greatest importance. Egon Larsen has, therefore, made an English translation of **Sex Problems in School**, by René Allendy and Hella Lobstein ($2.00. *Staples Press, New York City).*

The appearance of Dr. Kinsey's report emphasized the recurrent theme in the editorials of Henry McClure Young in the *Urologic and Cutaneous Review* over a period of 25 years. His widow has selected from hundreds of these the ones that seem to fit the current needs of our young folks, **Essays on Sex** ($5.00. *Christopher Publishing House, Boston, Mass.)* These essays contain many advance ideas that are the most stimulating of anything that I have read recently.

"In times when so much is heard of sexual difficulties and when the spot light of press and radio tend to be concentrated very largely upon certain aspects of sex, we do well to remind ourselves that a happy married life is not something extremely rare, but is in fact enjoyed by a great number of people." With these words, Eustace Chesser, M. D., begins her book on **Sexual Behavior, Normal and Abnormal** ($3.75. *Roy Publishers, New York City).* After a clear exposition of the "Sex Chains" and how they are forged to give normal and abnormal behavior, the author gives us three excellent chapters on reeducation for normal living which should prove helpful to all of us physicians—especially the majority who do not give sex much consideration.

Conditions in this whole field of sexology have been controlled by ignorance. Stekel maintains that in sexual matters doctors are dangerous laymen! Dangerous because they give professional advice to their trusting patients; laymen because in sexual matters they are burned by the superstition and prejudices to which they themselves had been exposed as children.

Stekel is the man who dealt the death blow to the superstition about masturbation. His observations he has finally summarized in **Auto-Erotism** ($4.00. *Liveright Publishing Corp., New York City).* This translation will prove helpful to all physicians who wish to inform themselves as well as their patients about this very important deviation.

Most of us are quite unfamiliar with the nature of sex crimes. J. Paul deRiver, M. D., criminal psychiatrist and sexologist to the Los Angeles Police Department, has brought out a psycho-analytical study of such cases from his own files, **The Sexual Criminal** ($5.50. *C. C. Thomas, Springfield, Ill.)* It is the author's rich experience which makes this book important to the rest of us if only we wish to understand the crimes currently displayed in the news.

Recent years have been full of critical questions concerning Alfred C. Kinsey's pioneer explorations in the tabooed territories of sex. Shortly after his report on the **Sex Behavior of the Male** appeared, Albert Deutsch assembled a symposium designed to present an interpretation of the major points entitled **Sex Habits of American Men** ($3.00. *Prentice-Hall, Inc., New York City).* Each contributor is an authority in this field. This book has done a great deal to make the Kinsey report successful.

This report and studies of the Committee for the Study of Sex Variants in the book, **Sex Variants**—A Study of Homosexual Patterns, by George W. Henry ($8.00. *Paul B. Hoeber, Inc., New York City),* make it clear that the problems of sexual adjustment are still far from solution. There is need for more knowledge and certainly for more respectability and understanding in the handling of the problem. The work of the Committee is all to this end.

A new book in this field of sex deviation is that by Louis S. London and Frank S. Capiro entitled **Sexual Deviations** ($10.00. *Washington Institute of Medicine, Washington D. C.)* It contains 700 pages of clearly organized authoritative information by men of broad experience.

ALCOHOLISM

Clinical experience shows that alcoholism is much less frequent in women than in men in a ratio of about 1 to 5. On the other hand, what alcoholic women seem to lack in quantity, they certainly do make up in "quality." They are more abnormal. This is usually ascribed to the fact that women are still subjected to more repressions than men. Dr. Benjamin Karpman, chief psychotherapist at St. Elizabeth's in Washington, has collected a series of case studies to show the psychodynamics of alcoholism in the book **The Alcoholic Woman** ($3.75. *The Linacre Press, Washington D. C.)* He has chosen that type of alcoholic woman for presentation in three cases with drunkened sexual careers of unusual promiscuity. In doing so he has deliberately ignored those into whose lives no sexual abnormality inserts itself—their neurosis taking another form.

These girls have missed nothing. There is a full-fledged Oedipus situation with all of its ramifications in aberrant sexual channels; masturbation, perversions—open or half-hearted—as well as incestuous and homosexual components. This is a strong book and has been characterized as pornography by some critics. Certainly we have a right, however, to a complete literature on alcoholism.



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JONATHAN FORMAN, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Foramen Magnum and High Cervical Cord Lesions Simulating Degenerative Disease of the Nervous System

KENNETH H. ABBOTT, M. D.

IN the past decade there has been a renewed interest in the differential diagnosis of the patient with bizarre and somewhat widespread neurologic signs and symptoms. This healthy reinvestigation into the problem has pointed our attention to the region of the foramen magnum and the upper cervical segments of the spinal cord as a locale of mass lesions, such as tumors, protruded intervertebral discs, and fracture dislocations, as the occasional cause of such bizarre symptom complexes. Not only are tumors, protruded discs, and fractures known to give rise to these syndromes, but also epidural thrombophlebitis and inflammatory processes and the syndrome known as platybasia or basilar invagination (basilar impression) probably are not infrequent causes of widespread neurologic signs so commonly attributed to the degenerative disease groups of the central nervous system. It is the purpose of this paper to give thoughtful consideration to such lesions as these in reference to their differential diagnosis from degenerative disease of the nervous system, such as multiple sclerosis, amyotrophic lateral sclerosis, posterolateral sclerosis, progressive spinal muscular atrophy, and kindred syndromes.

The cases herein reported will in part exemplify the error in making the diagnosis of degenerative disease on the basis of the bizarre neurologic picture alone. It is hoped that certain pitfalls in the diagnosis can be pointed out so that space-occupying lesions may be recognized and remedied before irreparable damage to the nervous system has resulted.

Presented before the Section on Nervous and Mental Diseases at the annual meeting of the Ohio State Medical Association, Columbus, April 21, 1949.

The Author

● Dr. Abbott, Columbus, Ohio, is a graduate of College of Medical Evangelists, 1936; fellow, International College of Surgeons and American College of Surgeons; member of Harvey Cushing Society, American Academy of Neurology, American boards of Psychiatry and Neurology, and Neurological Surgery; neurosurgeon, Mt. Carmel and Grant Hospitals; on neurosurgical staff, Children's, White Cross, University and St. Francis Hospitals; and instructor, neurology, College of Medicine, Ohio State University.

The first case herein reported, that of a meningioma of the foramen magnum, is of sufficient rarity and interest to warrant its being reported in detail. The other cases will be recorded in less detail, though they may be of equal interest, but they too emphasize the possibility of high cervical cord lesions giving rise to diffuse signs and symptoms.

REPORT OF CASES

Case 1. A woman, aged 50 years, of Jewish descent, was first seen on December 16, 1947. She had been well until three years prior to this time, when she had complained of tinnitus in the left ear. This was associated with "some difficulty in walking," which was described variously as "slightly drunk" or "unsteady" and was worse when the patient was walking in the dark. The tinnitus disappeared, and the walking improved. About two years previously (the fall of 1945) she had noticed the insidious onset of numbness in the tips of the fingers

of the right hand. Examinations made at this time had suggested a diagnosis of posterolateral sclerosis. By June, 1946, there was marked numbness of the right hand with definite loss of temperature sensation. At times her symptoms regressed; however, after a few months the numbness had progressed up the right forearm to the arm and then to the shoulder. Simultaneously with the sensory loss there was a mild motor deficit in the right hand and subsequently in the right lower extremity. By the fall of 1946 the sensory loss was severe in the right extremities. It seemed that pain and temperature senses were most severely affected, though other sensory modalities were also disturbed. In November, 1946, "a peculiar numbness" appeared in the left hand. After this there was rapid involvement of the entire left upper extremity, soon followed by sensory disturbance over the left breast and then of the left lower extremity.

In January, 1947, the patient had been examined by a competent neurologist, who noted that the symptoms of which she complained were those of "severe loss of use of the hands and arms," and "a drunken, wobbly gait." Examination at that time revealed marked hypesthesia of the right extremities with hyperesthesia and hyperalgesia (dysesthesia?) of the left extremities. Nystagmoid movements, positive Romberg sign, marked loss of vibratory sense in the left upper extremity, and poor execution of the finger-to-nose and finger-to-finger tests were observed. There was bilateral weakness in the upper extremities but more on the right than on the left. The deep reflexes were hyperactive in all four extremities with positive pyramidal tract signs. She was thought to have multiple sclerosis.

The patient was examined in February by two competent neurologists in a midwestern city, at which time pantopaque myelograms were made on two occasions. A diagnosis was made of multiple sclerosis or "an inflammatory lesion." In March and April she received roentgen therapy to the back of the neck without any improvement. During the following seven months there were many changes in her symptoms, varying back and forth from hypalgesia to hyperalgesia and at times what appeared to be actual improvement.

At the time of my first examination of the patient, she was complaining of inability to walk without assistance, numbness in both upper extremities and the right lower extremity with painful hyperesthesia and hyperalgesia in the right side of the thorax and the right lower extremity. Other symptoms of which she complained were inability to use the right extremities ("I drag my right leg like I'd had a stroke") and pain in the back of the neck and head on the left side with a sense of pressure in the left side of the head, particularly in the left ear.

The past history was not particularly of interest except possibly for an attack of stabbing pain in the left eye that had occurred five years previously and lasted only a few days. Three years previously she had experienced tinnitus which disappeared "after a few months." Two years previously, prior to the onset of the present symptoms, the patient had tripped, striking her head and also fracturing the left radius.

Neurologic examination made in December, 1947, did not disclose involvement of the cranial nerves. There was no nystagmus. There was marked weakness of both right extremities with only feeble movements in the right fingers and fair movement of the right leg, foot and toes. The right extremities were severely spastic, while there was slight spastic weakness of the left extremities. She was able to walk with aid.

The sensory examination was most interesting in that its results were exceedingly irregular. The right extremities disclosed marked sensory



Figure 1. Pantopaque myelogram, lateral view, disclosing partial block to flow of the opaque medium at C1 and outlining the lower border of the tumor.

loss to all modalities, but there were small areas which appeared normal or hyperesthetic and dysesthetic, the lower extremity being less affected than the upper extremity. The deep reflexes were all hyperactive with bilateral patellar and ankle clonus, all pyramidal tract signs being more marked on the left than on the right. The superficial abdominal reflexes were absent. Babinski, Oppenheim, Gordon, Gonda, Chaddock and Hoffmann signs were bilaterally positive. There was hypesthesia over the left second cervical dermatome.

Examination of the cerebrospinal fluid revealed 20 mg. of protein/100 cc.; the results of further analysis were also within normal limits.

The diagnosis of multiple sclerosis seemed the only probable one with such irregular sensory findings, although nystagmus, optic atrophy, and other cranial nerve signs were noted to be conspicuously absent, while the left suboccipital and posterior cervical pain seemed unusual for such a diagnosis.

The patient was seen on a few occasions in the following four months, during which time she became progressively worse. By the middle of April the neurologic status had become that of quadriplegia and of inability to move the head, associated with severe left suboccipital, occipital, and posterior cervical pain. Spontaneous pain in both upper extremities became more severe; however, there remained irregular sensory changes over the trunk and extremities and ability to move the toes of the left foot. The remainder of the neurologic status was about

the same except for moderate atrophy of the right extremities and slight atrophy of the left extremities. It was then evident that this patient did not have multiple sclerosis. A pantopaque myelogram (Figure 1) disclosed a large filling defect at the foramen magnum. A small amount of the opaque medium entered the posterior fossa. Thus, quite tardily a neoplasm in the foramen magnum was diagnosed.

On April 28, 1948, limited suboccipital craniectomy and bilateral laminectomy (C1 and C2) were performed. When the dura over the cisterna magna was opened, a reddish-brown tumor was seen to arise to the left of the midline and lie posterolateral to the medulla. The tumor, obviously a meningioma, extended from 4 to 5 cm. above the foramen magnum to the level of the upper border of the second cervical vertebra and caused severe compression and distortion of the medulla and adjacent cervical segment of the spinal cord. Careful dissection of the tumor disclosed that its origin was from a small area on the left posterolateral rim of the dura at the foramen, encircling the left vertebral artery.

The neoplasm was removed piecemeal, the vertebral arteries being spared. After this had been done, the dura was thoroughly cauterized.

The pathologist reported: "The specimen consists of a number of fragments of white, smooth, rather firm tissue, the total weight of which is 9.5 gm. A rapid frozen section was done on one of these fragments with a diagnosis of meningioma. Microscopic sections (Figure 2)

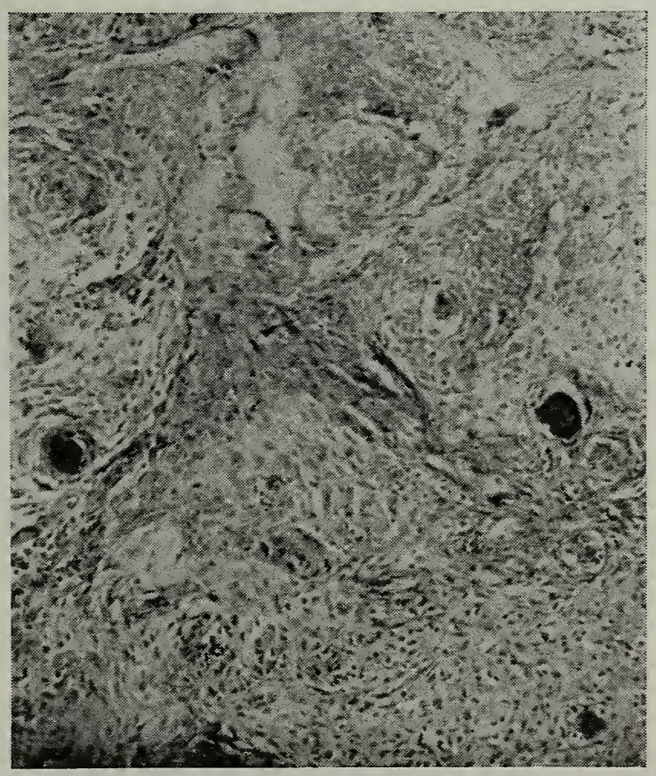


Figure 2. Meningioma of the foramen magnum. Note its uniform fibrous structure and the presence of psammoma bodies (hematoxylin and eosin x 100).

of the fixed tumor showed it to be made up of moderately staining, clumped, spindle-shaped cells arranged quite frequently in a whorled manner. Scattered throughout the specimen but quite frequently seen are small round nodules made up of blue-staining crystalline material (calcospherites). The tumor is moderately vascular and in one area there is evidence of fresh hemorrhage." The diagnosis made by the pathologist was meningioma, fibrous type, with psammoma (Courville-Abbott classification).

The patient awakened promptly, and examination eight hours after operation disclosed an early return of motor function in the right arm. Twenty hours after operation she could move both left extremities and the right upper extremity. On the third postoperative day she was able to move all four extremities. On her ninth postoperative day she took a few steps with the assistance of two nurses, and at the same time sensory function was definitely returning to normal in all four extremities. By the end of three weeks she was able to walk across the room by herself, and after six weeks she was able to care for herself at home.

In September, 1948, the patient began to drive her own car and made no complaints aside from moderate fatigability. Examination in September revealed normal cranial nerves, no sensory deficit except for slight hypesthesia in the right hand, no spasticity or rigidity, and only moderate general weakness in the extremities, which seemed to be due to the slow return of function in the atrophic muscles. The superficial abdominal reflexes were bilaterally weakly obtained. A positive Babinski sign remained on the right side.

* * *

Case 2. A white man, aged 32 years, of Irish descent, was seen because of intermittent numbness in all four extremities with weakness in the right upper and left lower extremities of two years' duration. He had consulted several competent internists and neurologists who had diagnosed the condition as multiple sclerosis, posterolateral sclerosis, and "a degenerative disease of the nervous system." My examination disclosed marked weakness of the right upper and left lower extremities with slight weakness in the other extremities. There was an irregular sensory loss, very difficult to map out, but showing distinctly greater pain and temperature loss in the right extremities and irregularly decreased appreciation of vibratory and position sense in the left hand and both legs and feet. Touch and pressure were relatively intact in all four extremities. In the previous month he had experienced pain over the left occipital area and slight hyperalgesia was present over the left occipital area and slight hyperalgesia was present over the distribution of left C2.

A myelogram disclosed a large defect in the pantopaque column with almost complete block at the lower border of the body of C2 on the left side. A meningioma, situated posterolaterally (left) to the spinal cord and arising from the spinal meninges along the lower border of C1 to the lower border of C2, was removed surgically without incident. The patient was followed for six months after operation, and at the end of that time had made a complete neurologic recovery aside from numbness over the left C2 dermatome (left C2 had been sectioned in order to remove the tumor).

* * *

Case 3. A white man, aged 57 years, a mechanic, was known to have had a fractured odontoid process some two years before. He was seen in consultation because of intermittent weakness of the extremities (occasionally one arm or leg, or even all four extremities) and peculiar patches of paresthesia in the left side of the face and upper extremities.

He had complained of "burning sensations,"

"numbness," and "tingling" for short intervals in the left cheek and eye. These had occurred at varying times (some ten to fifteen times) over the previous year and lasted from a few minutes to hours. The attacks of weakness were all very transitory and most commonly involved the lower extremities simultaneously and occasionally the right arm and hand. Usually when such motor attacks occurred he would experience vague sensory difficulties expressed variously as "a little numb and tingling," "slightly burnt fingers," and so forth. He had consulted several internists and a neurologist, all of whom suggested he might have multiple sclerosis.

Neurologic examination disclosed dysesthesia over the left cheek, slightly and irregularly hyperactive deep reflexes in all extremities, decreased superficial abdominal reflexes and bilaterally equivocally positive Babinski signs.

Roentgenograms of the cervical vertebrae disclosed that the previously fractured odontoid process was displaced slightly posterior with considerable calcium deposited at the fracture line about its base at the point of its union to the body of C2.

The patient refused surgical decompression of the spinal cord by laminectomy. I have been unable to trace him since then.

* * *

Case 4. A school teacher, aged 33 years, came for relief of headaches, difficulty with vision, awkwardness in the use of the upper extremities, and odd attacks of numbness in the hands and feet.

The neurologic examination was not at all satisfactory. There were slight ataxia of the left upper extremity and paresthesias in both hands with periods of paresthesias in both feet (pinprick frequently was recognized as "a burning point"). The deep reflexes were quite irregular not only at the time of the original examination, but at subsequent examinations. At no time was the neurologic picture consistent, though a definitely positive Babinski sign was occasionally obtained on the right and an equivocal Babinski sign on the left. The optic fundi were within normal limits. There was no evidence of papilledema or optic atrophy. Occasional nystagmoid movements were noted, but no definite nystagmus. The Wassermann reactions of the blood and cerebrospinal fluid were negative for syphilis.

From the neurologic examination one would expect that this patient might be suffering from a degenerative disease of the nervous system such as multiple sclerosis; however, roentgenograms of the skull disclosed a mild but definite platybasia. Suboccipital craniectomy and upper cervical laminectomy confirmed this diagnosis. An adequate decompression of the posterior fossa and upper cervical segment of the spinal cord gave almost complete relief from all symptoms.

COMMENT

The earliest review of spinal tumors that lie above the C4 segmental level appears to have been that of Antoni in 1920.[1] Prior to this they were of interest only as pathologic museum specimens and, as pointed out by Cushing and Eisenhardt,[2] this "was true of the example described by Antoni (Case XXI) which since 1862 had been in the museum at Lund." Surgical repair on these tumors soon followed Antoni's report, such as that of Frazier and Spiller[3] in 1922, Learmonth's[4] in 1927, and Elsberg and Strauss[5] in 1929 along with other increasingly frequent reports in the literature since that date. However, Bogorodinsky[6] appears to have been the first to review the various syndromes resulting from tumors arising primarily in the foramen magnum. His principal conclusions have been summarized by Cushing and Eisenhardt[7] as follows:

1. Extramedullary tumors located at the juncture of the oblongata and the spinal cord (that is, craniospinal tumors) run a stereotyped clinical course which gives rise to a definite syndrome.

2. The onset is characterized by suboccipital discomforts, protective rigidity of the cervical and occipital musculature, and sometimes by pains and paresthesias in the shoulder girdle and upper extremities.

3. At its maximum stage the clinical symptoms are as follows: (1) Paralyses of the extremities (hemiplegia, triplegia, or tetraplegia). (2) Rigidity and paresis of the cervical muscles, abnormal posture of the head, and paresis of the XI pair of cranial nerves. (3) Pains and paresthesias in the extremities and trunk. (4) Pains in the occiput and the neck. (5) Hemianesthesia or para-anesthesia reaching up to the upper cervical dermatomes occasionally involving the skin field of the trigeminus. (6) Sphincteric disturbances. (7) Respiratory disturbances. (8) Horner's symptom-complex. (9) Cerebral symptoms such as paralyses of the X, XI, and XII pairs of cranial nerves and choked discs are of infrequent occurrence.

4. Three different types of syndrome may be distinguished: (1) the hemiplegic; (2) the paraplegic, which may take either the descending or the ascending form; and (3) the mixed type.

5. The paralyses of the upper extremities reveal signs of their derivation from lesions of both peripheral and central neurons.

6. The striking sensory features are thermic paresthesias and the peculiar distribution of disturbances which takes the form of hemianesthesia alternans cum radic. cervicalis.

7. Cerebral and cerebellar symptoms are both mild and infrequent.

8. Vegetative symptoms such as Horner's syndrome, respiratory and sphincteric disturbances should be regarded as due to lesions of the pyramids and of the central sympathetic.

9. The course of the malady is slowly progressive, lasting for months and even years, though remission of isolated symptoms may occasionally be observed.

10. The degenerative atrophies are not limited to the level of compression but involve the cervical, the thoracic and sometimes even the lumbar segments of the cord.

11. The extirpation of the tumor by surgical interference has proved to be an efficient method of treatment in 50 per cent of the cases that were operated on.

Although Bogorodinsky[6] emphasized the variation of symptoms that foramen magnum tumors may present as they grow, it probably was Friedman[8] (and later Neri,* [9] Roussy and Levy,[10] Friedman[11] and Schick[12]) who called attention to the fact that such a tumor may simulate a degenerative disease of the central nervous system such as combined system disease. Friedman[13] in 1941 again called attention to this in a case report and noted the tendency for remission of symptoms, the condition thus resembling multiple sclerosis. Others (Ecker,[14] and Bennett and Fortis[15]) have reported cases in which a diagnosis of syringomyelia (disassociated syndrome) might justifiably have been made. Bennett and Fortis[15] emphasized that at some time in the course of development of tumors of the foramen magnum there is reason to consider in the differential diagnosis amyotrophic lateral sclerosis, combined system disease, multiple sclerosis, and syringomyelia. The diagnosis in the case of Gardner[17] and his coworkers was complicated by a positive serologic reaction for syphilis, a complication which delayed recognition and removal of the tumor.

In my case (Case 1) the neurologic signs, particularly the sensory findings, were irregular, at times suggesting a combined system disease. Later on in the clinical course the picture appeared so bizarre that a diagnosis of multiple sclerosis seemed justified. However, it would appear most important to emphasize the severe pain in the left suboccipital, occipital and posterior cervical areas as well as in the upper extremities. This distribution of pain, together with the picture of progressive quadriplegia, should have been enough to force one to make the correct diagnosis of tumor of the foramen magnum. However, it was not until total paralysis appeared that the fallacy in diagnosis demanded restudy of this patient. This now seems an inexcusable error. Certainly when severe suboccipital and neck pain appears associated with one of the foregoing neurologic syndromes, the examiner should first think of a tumor of the foramen magnum and then attempt to prove or disprove this diagnosis rather than give way to the hopeless diagnosis of a degenerative lesion.

Cushing and Eisenhardt[18] called attention to the fact that this group of meningiomas should be divided into two distinct subgroups: (1) Those arising from the basilar (occipital) groove or process, and (2) those arising from the spinal canal. The former group they called "craniospinal" after the suggestion of Bogorodinsky,[6] since these tumors primarily arise intracranially and extend down through the foramen magnum. These tumors are all situated anterior or anterolateral to the medulla. The second group, the spinocranial meningiomas, are located posterior or posterolateral to the medulla.

In either group a fairly large mass of tumor may be found intracranially; but, as Cushing and Eisenhardt emphasized, it is the craniospinal meningiomas which have been a most difficult surgical problem. However, Cushing and Eisenhardt[19] stated: "Whether a meningioma arising from the basilar groove which must be overlain and concealed by a posteriorly dislodged medulla and its emerging nerves could be safely exposed and surgically enucleated must be left for further experience to determine." Since then Voss,[20] Ecker,[14] Keegan,[21] and others[22, 23] have removed successfully craniospinal meningiomas and there has been a growing list of spinocranial meningiomas successfully removed.

The greater technical difficulties encountered in the surgical attack on craniospinal tumors suggested to me that it would be of interest to review their symptoms and determine if it is possible to differentiate clinically between the two groups (craniospinal and spinocranial). As has been shown, the syndrome of unilateral sensory changes of an upper extremity associated with either unilateral or bilateral pyramidal tract signs and symptoms is common to both the spinocranial and the craniospinal tumors. However, it was noted that spinocranial meningiomas tend to produce more severe suboccipital and occipital pain than craniospinal meningiomas produce. This is probably because the second cervical root is acutely stretched across the posteriorly or posterolaterally situated tumors, as was pointed out by Cushing and Eisenhardt.[24] In the craniospinal tumors not infrequently there is considerable suboccipital aching, but from the reported cases and those that I have had the privilege of studying in a large neurosurgical clinic, the suboccipital symptoms are not as severe as those encountered in the spinocranial group. (Gardner has called attention to the presence of sensory loss in the ipsilateral C_2 dermatome.)

A review of other symptoms failed to suggest any other difference in the two groups, even though it would seem that the craniospinal group from their position might produce pyramidal tract signs earlier and with more severe symptoms of motor deficit subsequently developing; however, this was not borne out. To be sure, it was not always possible to determine in every case report whether the origin of the tumor was intracranial or intraspinal.

At the time of the surgical removal of the tumor (spinocranial) recorded in Case 1, I was particularly interested in noting the point of

* More specifically referring to high (C1) lesions of the cervical segment of the spinal cord.

attachment to the leptomeninges and dura. It seemed of importance to note that the origin of the tumor was on the left posterolateral margin of the dura over the rim of the occipital bone forming the foramen magnum and also encircling the left vertebral artery. The attachment was very discreet and well demonstrated. The elementary question again arises whether this origin is spinal or cranial. The location suggests that this tumor originated intracranially or at least it might be considered to have had a cranial origin though, to be sure, it did not arise from the occipital basilar groove.

The danger of lumbar punctures with the removal of fluid in cases of spinal and intracranial tumors (particularly in the posterior fossa) has been well recognized for many years[25] but probably is more forcefully brought to attention in reviewing the foraminal tumors of this group. In more than 70 per cent of the reported cases in which the dynamic relations of the cerebrospinal fluid were interfered with by lumbar puncture, the symptoms were immediately made worse. Bennett and Fortis,[15] who again called attention to this fact, had to place their patient in a respirator for three months after lumbar puncture. However, the symptoms of the patient in Case 1 did not appear to be aggravated immediately, either by lumbar puncture alone or by the multiple pantopaque myelographies performed via the lumbar route.

Although an increased total protein in the cerebrospinal fluid should suggest the possibility of a neoplasm, Friedman[13] and others have reported normal concentrations of total protein in the cerebrospinal fluid. This was also the situation in Case 1. Thus, unless there is an obstruction to the flow of the cerebrospinal fluid or embarrassment of local circulation, the total protein in the cerebrospinal fluid may not be elevated.

Any patient giving evidence of sensory changes (paresthesias or sensory loss) in one or both upper extremities associated sensory changes in either C_2 dermatome and with pyramidal tract signs (ipsilateral, contralateral, or bilateral) should be considered as possibly having a tumor of the foramen magnum. Other syndromes, such as Brown-Séquard, disassociated, and combined system, and multiple sclerosis syndromes, particularly if associated with suboccipital pain or aching, should arouse strong suspicion of the presence of a spinocranial or craniospinal or high cervical cord tumor. The absence of an increased concentration of protein in the cerebrospinal fluid does not argue against the probable presence of these lesions. Although palsies of the cranial nerves (tenth, eleventh, and twelfth) may occur, as well as diplopia and cerebellar signs, they are more commonly absent.

Severe occipital and suboccipital pain associated with the foregoing symptoms suggests that the lesion is a spinocranial tumor and, if so, more easily amenable to surgical attack than a craniospinal tumor.

It would seem advisable to perform myelography in all such patients rather than to allow quadriplegia to develop before the diagnosis is made, or to find the tumor at postmortem examination.

Although this discussion has centered mainly around tumors of the foramen magnum, similar remarks might be directed toward the tumors cephalad to the fourth cervical segment. However, in most of these tumors there is usually evidence of involvement of one of the upper cervical nerve roots together with pyramidal or sensory tract signs. To be sure, many of these tumors, if not the majority of them, give a progressive course typical of tumor, though there is an occasional one, such as described in Case 2, in which there is a wide variation in the symptoms with complete remission of all subjective symptoms and possibly signs. The same is probably true of an occasional fractured odontoid process, as mentioned previously.

Of considerable interest are the groups of patients suffering from platybasia or so-called basilar impression or basilar invagination of the skull which in recent years has been emphasized by Chamberlain[26] and by Gustafson and Oldberg[27] and others. Usually the obvious cases are diagnosed from the roentgenograms; however, those cases which can be considered from the roentgenographic evidence as being borderline cases are the ones that may give rise to difficulties in their diagnosis. Such cases, however, may show marked changes at the time of operation. In one such case (Case 4) that I have encountered, there was evidence of extensive adhesions and arachnoiditis associated with what might be considered "grade 1+" platybasia. In this case there was marked obstruction of the subarachnoid space with highly bizarre and changing neurologic symptoms, which at first were thought to be due to multiple sclerosis. In such cases the patients may and frequently do respond very well to surgical decompression. Thus again in all cases of suspected degenerative diseases, such as multiple sclerosis, and so forth, the patient should be given the benefit of roentgenographic study for the possibility of platybasia being present.

Another group of cases in which we are not primarily interested here, but which should be mentioned are those on which Fay[28] has focused attention in which, in his opinion, there has been an inflammatory process in the upper cervical epidural area. These he refers to as cases of "epidural thrombophlebitis" and "epidural inflammation with secondary involvement of the

spinal cord." There are some neurologists who undoubtedly give very little credence to this diagnosis. I have had a very limited experience in this field, having seen only two such cases in which there was obvious evidence of infection at the level of C2 in one case and C3 in another. When the dura was opened, marked adhesions between the arachnoid and the dura and between the arachnoid and the spinal cord were encountered. The operation was done in both instances with the purpose of performing a rhizotomy for local (radicular) pain; at the same time minimal motor or sensory long tract signs had been found prior to operation. The pantopaque myelogram had shown an irregular defect at this level which I felt must be due to arachnoiditis. It seems probable therefore that more severe infections might give rise to symptoms not unlike multiple sclerosis or amyotrophic lateral sclerosis or both. Neither of these patients showed any change in his neurologic status aside from the minimal sensory loss following the posterior root rhizotomy. However, it may be that as a result of further investigation by way of surgical exploration on those patients who show the so-called spinal type of multiple sclerosis similiar inflammatory lesions will be found by other surgeons, and Fay's reports will thus be confirmed.

I have not had experience with patients suffering from protruded cervical discs in the upper cervical segments; hence, I have only mentioned that they may, in all probability, give rise to syndromes similar to those under discussion. The reports of Bucy[29] and others appear to confirm this.

SUMMARY

Any patient giving evidence of sensory changes, paresthesias or sensory loss in either C_2 dermatome and in one or both upper extremities associated with pyramidal tract signs, ipsilateral, contralateral, or bilateral, should be considered as possibly having a tumor of the foramen magnum, an upper cervical tumor, or other space-occupying lesion, regardless of whether or not these symptoms are accompanied by evidences of intracranial changes. Other syndromes, such as Brown-Séquard, dissociated syndrome, combined system disease, and multiple sclerosis syndrome, particularly if they are associated with suboccipital pain or aching, should arouse strong suspicion of the presence of a high cervical, spinocranial, or craniospinal neoplasm or of a protruded intervertebral disc in the cervical segments cephalad to C4. The absence of an increased concentration of protein in the cerebrospinal fluid does not argue against the probable presence of these lesions. If such syndromes are accompanied by palsies of the tenth, eleventh, and twelfth cranial nerves or even by diplopia and cerebellar signs, their presence does not rule out the presence of a tumor in this region though these symptoms are commonly present in degenerative lesions of the nervous system. If any of these syndromes are present, the possibility of basilar invagination (platybasia) must also be suspected. Severe occipital or suboccipital pain associated with the foregoing symptoms suggests that the lesion is a spinocranial tumor and, if so, is more amenable to surgical attack than a craniospinal tumor. It would seem advisable to perform myelography in all such cases rather than to allow quadriplegia to develop before the diagnosis is made or to find the tumor at postmortem examination.

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The Emergency Management of Acute, Massive Upper Gastrointestinal Hemorrhage

STANLEY O. HOERR, M. D.

THE patient who suddenly vomits blood or passes a large tarry stool invariably presents a troublesome problem to the physician responsible for his care. The well-known fact that most of these acute hemorrhages subside spontaneously is of small comfort when one is dealing with a particular individual whose death, if he should exsanguinate, will be complete, even though this same death may be expressed as a tiny percentage in a large series of cases.

The first question the physician must ask himself is this: Is the bleeding so rapid that death may occur in a matter of hours? It is unnecessary to have elaborate aids in deciding this point, and it takes priority over every other consideration. The clinical evidences of shock—weakness, pallor, a weak, thready, rapid pulse, and cool, damp extremities—bespeak a serious and rapid loss of blood. If shock is present, the immediate requirement is support of the circulation, and the most effective means is by prompt blood transfusion. Contrariwise, a patient who is warm and has a slow full pulse is safe, for the moment at least, insofar as his circulation is concerned. If one sees a patient very soon after the onset of bleeding, it is possible to misinterpret the syncope or faintness, which often accompanies the effort of vomiting or moving the bowels, for hemorrhagic shock; the lapse of a few minutes, and the prompt improvement which results from simple recumbency, will assist in the differentiation. But if doubt persists, it is far better to give a blood transfusion which in retrospect proves to have been unnecessary, than to withhold blood from a patient who badly needs it.

RATIONALE OF BLOOD TRANSFUSION

This prompt and liberal use of blood transfusion for the patient with a serious hemorrhage represents a departure from practices of the past. It has been taught by able clinicians that "shock" and its lowered systolic blood pressure is actually beneficial to the patient by permitting a clot to form over the site of the bleeding, and it has been argued that to raise the blood pressure to normal levels too quickly, by giving blood, will "blow off the clot" and start fresh bleeding. This point of view is no longer held by most investigators of the problem. The practical dangers of a prolonged hypotension, resulting in irreversible renal damage, or precipitating a coronary or cerebral thrombosis in an elderly person, is held to outweigh the theoretical possibility of renewing the bleeding. Most patients in actual or impending shock respond satisfactorily to a single transfusion of 500 cc whole blood, but an occasional badly depleted patient may require up to 1500 cc in the first five or six hours. Plasma is not an adequate substitute for whole blood, although it may sometimes act as an indispensable stop-gap during the time that properly cross-matched whole blood is being secured. The use of the usual electrolytes—glucose in water, or glucose in saline—is to be condemned; although these solutions will temporarily increase the blood volume, their ultimate effect is deleterious through a relative reduction of the essential components of the blood stream.

INITIAL EXAMINATION

While the state of the circulation is being ascertained, the physician may examine the nose, mouth and throat, listen to the chest, gently palpate the abdomen (looking especially for epigastric masses or an enlarged spleen), and perform a rectal examination. This will enable him to exclude the oropharynx as a source of bleeding, to rule out gross pulmonary lesions which might cause confusion between hemoptysis and hematemesis or to suspect a gastric neoplasm. If the spleen is palpable, bleeding from esophageal varices is always to be considered. Tarry feces on the glove will confirm the fact that bleeding is high, and very rarely a rectal neoplasm or a Blumer's shelf will shed unexpected light upon the basic diagnosis.

In the severe bleeder it is always desirable to obtain baseline determinations of the total erythrocyte count, hemoglobin, hematocrit and total plasma protein. The initial values will not influence the decision concerning an immediate blood transfusion, but they will prove of great

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value in estimating the progress and rate of hemorrhage, and the adequacy of blood replacement by comparison with samples taken later. In interpreting the admission values it must be remembered that a nearly normal blood count is not inconsistent with a massive hemorrhage of short duration; and on the other hand, that a severe anemia does not necessarily mean a massive hemorrhage, but may merely reflect a chronic loss of blood.

GENERAL MEASURES

After the institution of any indicated therapy for hemorrhagic shock, adjuvant measures are in order. If the patient is in pain or has severe discomfort, demerol will probably be preferable to morphine, since it does not increase gastrointestinal tonus. The fears of an apprehensive patient who is free of pain are best allayed with a barbiturate. An ulcer-type diet with nonabsorbable alkalis may be started almost at once providing that the patient has not been vomiting. Such a feeding regimen is beneficial if the lesion is a peptic ulcer or gastritis (which together account for about 80 per cent of all cases of massive upper gastrointestinal hemorrhage), and will not be harmful if the bleeding is due to some other cause. On the other hand, if the patient is retching and vomiting, the stomach should be kept empty by means of a Levine tube attached to constant suction. The danger that such a tube may increase bleeding by passing over the lesion would seem to be less than the strain imposed by vomiting. Ice applied externally to the epigastrium is to be avoided, because it increases gastric motility. Some investigators are advocating the oral administration of thrombin in doses of 10,000 Iowa units in an effort to promote clot formation at the bleeding site. It is difficult to see how this can affect bleeding from a large artery, but there can be no harm in using it.

METHOD OF OBSERVATION FOR FURTHER HEMORRHAGE

When the physician has taken the preliminary measures outlined above, he may ask himself a second question: Will the bleeding stop spontaneously? It is assumed by nearly all investigators that a spontaneous arrest of the hemorrhage is the happiest outcome for all concerned The alternative treatment, an emergency operation, is not applicable to bleeding from esophageal varices, nor to that small but important group in whom the bleeding appears to come from numerous sites often too minute to visualize even at autopsy (as in a blood dyscrasia). Even when the lesion is a discrete one in the stomach or duodenum, a gastric resection is nearly always indicated—a formidable procedure in these poor-risk patients. Fortunately, an emergency operation is rarely needed, but since it will offer an occasional patient his only chance of survival, the physician must attempt to select that patient as promptly and accurately as possible.

The selection of this patient who will die without an operation can rarely be made within the first six or eight hours of hospitalization. Many patients will continue to bleed for some hours after treatment is first started, and fairly brisk hemorrhages lasting for several days may still cease spontaneously. The next step to be taken by the physician, therefore, is to set up a means of continuous observation which will make apparent any deterioration of the condition of the patient.

A useful plan for observation is the following:

(1) A chart of the pulse and blood pressure. These determinations are made and recorded by the nurse at intervals of 15 to 60 minutes. This not only supplies the physician with a graphic record, but permits him to write orders covering the giving of additional blood during his unavoidable absences. Thus an order may be written: "Notify doctor and start blood transfusion if systolic blood pressure falls below 90 mm Hg," or "Call doctor if pulse rate exceeds 120 or systolic blood pressure falls below 100." Sharp increases in pulse rate or drops in blood pressure are danger signals which should be heeded, and may herald a recurrence of very rapid bleeding.

(2) A determination of total erythrocytes, hemoglobin and hematocrit every eight hours, day and night. Successive values will show the over-all trend. Progressive drops will indicate either inadequate blood replacement, or persisting hemorrhage, or both. Some hemodilution is to be expected for twenty-four hours or more after the cessation of a massive hemorrhage.

(3) The bedside appraisal of the patient at intervals not to exceed eight hours for the first day at least. The chart may be reviewed, and the occurrence of hematemesis or melena ascertained. (The physician should recall that tarry stools may persist a day or longer after bleeding has ceased.) Patients who have ceased bleeding generally show a steady improvement both in appearance and sense of well-being.

INDICATIONS FOR EMERGENCY SURGERY

This triple check-up on the patient will determine quite clearly whether or not he is continuing to bleed. At University Hospital the clinical rule has been found helpful in which a pint of blood is given every eight hours, if the patient's condition demands it; if this much blood fails to hold him in circulatory equilibrium it is assumed that bleeding is from a large vessel, that spontaneous arrest is unlikely, and emergency surgery should be planned. Spontaneous arrest also is deemed unlikely in the patient who appears to bleed intermittently but very rapidly, lapsing into shock or syncope on one or more occasions while under

treatment, after quiescent periods which may last up to several days.

It will be noted that nothing has been said up to this point about the effect of the age of the patient in deciding for or against operation. Although the age factor has been stressed by various eminent surgeons, some of whom advocate emergency surgery in every patient over 50 years of age who presents himself with a massive hemorrhage, it is well known that a majority of older patients will respond to nonoperative measures. It seems more logical, therefore, to exercise selection in these patients, also, on the basis of the criteria already outlined. It is true, however, that the majority of emergency operative procedures will be performed in the older age group, for two reasons: (1) arteriosclerosis is often present in the eroded blood vessels, and loss of vessel contractility may interfere with the spontaneous arrest of bleeding; (2) older patients tolerate blood loss and shock less well than their younger brothers. The elderly patient must therefore be observed with especial care, and in the border-line cases one should favor surgery.

It has been observed by many clinicians that the longer the hemorrhage has lasted, the heavier becomes the operative risk. Some surgeons refuse to operate upon patients who have been bleeding for more than forty-eight hours. This contraindication to emergency surgery has assumed less importance in recent years. It will usually be possible to decide for or against operation within an observation period of twenty-four to forty-eight hours, but if a sound reason for surgery should become manifest after this time, operation is still justified.

INDICATIONS FOR EMERGENCY X-RAY

As long as the patient is doing well on a conservative regimen, it is not necessary for the physician to know the exact source of the bleeding. If the patient is going to require an operation, however, the source of bleeding becomes of great practical significance and the physician must ask himself a third question: Is the bleeding lesion amenable to emergency operation? In some patients previous X-ray or gastroscopic studies will have established the existence of a gastric or duodenal ulcer. All too frequently, however, the most serious hemorrhages are first hemorrhages in patients upon whom no diagnostic studies have ever been made. It is unwise to depend upon a clinical diagnosis in such a patient. Even though his condition is poor, he should be taken to the X-ray department for an emergency barium swallow to be administered by the senior roentgenologist. Blood should be available during this examination. The presence or absence of esophageal varices is first determined; if present, they are the presumptive source of hemorrhage, and emergency operation will not help. If a definite lesion in stomach or duodenum cannot be demonstrated, it is probably wiser to refuse surgery, transfuse further, and hope for recovery.

OPERATIVE PROCEDURE

The patient who comes to operation is one who has either lapsed into shock from rapid bleeding on one or more occasions while under treatment, or has failed to hold his own while receiving 500 cc blood every eight hours. He has a proved lesion in the stomach or duodenum. He is critically ill and a poor surgical risk, but the risk of not operating is felt to be even greater. A general anesthesia will be required. At least six pints of compatible blood should be available for use in the operating room. A direct attack is made upon the bleeding lesion. If the lesion is in the stomach, a gastric resection, including the lesion, is carried out. If the lesion is in the duodenum, it will be excised if possible; if not, the vessels in the ulcer bed will be ligated. Whether the ulcer is retained within the duodenum or not, the duodenal stump is turned in and the gastric contents permanently diverted by means of a gastric resection including at least 50 per cent of the stomach. It is not enough merely to ligate the vessels, through a gastrotomy or duodenotomy; after such a procedure the incidence of fatal secondary hemorrhage within a few days of operation is very high. An emergency vagus resection is contraindicated.

SUMMARY

The primary need of a patient with acute massive upper gastrointestinal hemorrhage is support of the circulation by blood transfusion. Most of these hemorrhages subside under conservative management irrespective of the source of the bleeding. Plans are presented for determining promptly the continuation of dangerous bleeding, and for selecting the occasional patient who will require an emergency operation to arrest the hemorrhage.

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Clinical Significance and Management of the Hypasthenic Patient

JOSEPH M. HAYMAN, JR., M.D.

FROM its derivation hypasthenia means a little asthenia, and may be applied to the large group of patients who come to our offices complaining of weakness or fatigue.

Common lay and professional opinion regarding the usual causes of hypasthenia are quite divergent. The former think of vitamin deficiency (thanks to effective advertising campaigns), constipation, sluggish liver, a weak heart, tuberculosis, or cancer. The physicians think of Addison's disease, hypotension, hypoglycemia, anemia, myxoedema, hyperthyroidism, undulant fever, or a pleuroglandular endocrine dysfunction.

A few years ago, Dr. F. N. Allen[1] reviewed the records of 300 patients studied at the Lahey Clinic because of complaints of weakness, fatigue, or weak spells. Physical disorders were found to explain the complaint in 61 patients or 20 per cent while "nervous conditions" were held responsible for 80 per cent. In the group in which physical disorders were believed responsible for the symptoms, the diagnosis was made in 28 or 46 per cent by routine history and physical examination, while the others, or slightly over half, required more or less laboratory investigation.

If in anything like 80 per cent of patients with hypasthenia the symptoms are due to emotional stress, this possibility should certainly be considered from the first visit. A diagnosis of functional disorder must not be made by exclusion, but on just as characteristic symptoms and signs as those of any organic diseases. Moreover, it must never be forgotten that a patient may have serious organic disease and serious functional disease at the same time, both of which require treatment. The history must include more than just a list of symptoms and previous diseases. There are a number of points which are characteristic of hypasthenia of nervous origin. The feeling of weakness is greatest in the morning, wearing off during the day; it varies greatly from day to day without change in activity; it is temporarily improved by a great variety of unrelated drugs. The duration of symptoms and the relation of their onset to events in the family or business are important guides. The patient who has been tired all of her life, who has never felt well, is probably not seeking help because of organic disease. The larger group of functional hypasthenias, however, give quite a different story. They got along fairly well up to a certain point, and can usually tell quite accurately when they began to have symptoms. A little careful questioning will usually bring out that this has coincided with prolonged periods of work under strain, another woman, or business reverses. It is common in women at the menopause, when the children are grown and no longer dependent while the husband is more and more taken up with business and golf and correspondingly forgetful of birthdays and anniversaries. These are much more important etiological factors than decrease in ovarian function.

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METHOD OF STUDY

After the history, with an attempt to get a picture of the whole patient, his background—social, economic and emotional as well as medical—every hypasthenic patient should have a thorough physical examination, and a few routine laboratory tests. These are a urinalysis, hemoglobin, white count, smear, and STS. A roentgenogram of the chest is always indicated in young people who have recently begun to feel tired, and is advisable at all ages. If the physical examination and these laboratory tests do not furnish any lead or evidence of organic disease, it is usually more profitable to go back to the history in an effort to learn more about the patient than it is to multiply laboratory procedures. The patient whose functional hypasthenia is "benign," of short duration and due chiefly to environmental factors, is relieved to know that he has no evidence of organic disease. The psychoneurotic on the other hand does not accept it, or seems disappointed. Extensive laboratory investigation is bad for the latter group. It gives them the feeling that they have some obscure disease which the doctor

cannot find but that perhaps if he did one more test or X-ray he might find it. They are apt to go from place to place seeking a more "thorough" examination.

CLASSIFICATION

This leads to a classification of hypasthenic states. For the purpose of management they may be grouped into:

1. Early symptoms of organic disease.
2. Post infectious hypasthenia.
3. Constitutional inferior, and neurocirculatory asthenia.
4. Psychoneuroses.

Complaints of abnormal weakness, lassitude, depression, inability to concentrate, associated with infection or organic disease are usually of short duration, are progressive in intensity and usually accompanied by loss of weight and fever. Of infections, tuberculosis, subacute bacterial endocarditis, rheumatoid arthritis, and syphilis are the most important, and the diagnosis or at least, a lead should be obtained by the history, physical examination and routine laboratory tests outlined. I have, perhaps erroneously, omitted chronic brucellosis and focal infections from this list. Chronic brucellosis, of course, does occur, but not as frequently as the diagnosis is made. In addition to the general symptoms of hypasthenia, chronic brucellosis presents fever, arthralgia and a positive agglutination reaction. A positive skin test simply indicates that the patient has at some time in the past come in contact with the antigen, and is not evidence that the present symptoms are due to brucellosis any more than a positive tuberculin reaction is evidence of active tuberculosis. Nor have I included "focal infections," whether in teeth, tonsils, prostate or tubes among the causes of hypasthenia. If any of these are found in the course of the preliminary examination, they should be properly treated. But the wholesale extraction of teeth, removal of tonsils, and suspension of uteri usually results in an increase rather than amelioration of symptoms. Nor can I agree with Turnbull's belief[2] that "toxic allergens" from food poisoning are a common etiologic factor in the tired, weak, exhausted, depressed patient. Food sensitivity can produce many and bizarre symptoms, but there are usually more violent symptoms at least intermittently—such as migraine headache, vomiting, or hives, in addition to those of hypasthenia. If no lead is derived from history, and the suspicion of sensitivity is still entertained, its significance can be determined by two weeks on a rigid elimination diet as suggested by Rowe.

The early stages of cancer are not characterized by hypasthenia, although this is a common fear of many patients, some of whom return year after year with the conviction that they have malignant disease, and only beg the doctor to find where it is. Hodgkin's disease and the lymphoma group present a much more difficult problem, but biopsy of an enlarged lymph node or a recurrent Pel-Ebstein type of fever should point the way to the correct diagnosis.

Hypotension and hypertension per se are rarely the cause of hypasthenic symptoms. Hypotension does occur in a number of patients with these complaints,[3] and hypertension in an even greater percentage. Under normal conditions the blood pressure in the aorta is about 10 mm. higher than in the brachial artery, and about 10 mm. lower in the digital arteries. This represents a drop of approximately 20 mm. from the aorta to the periphery. Beyond the arterioles the pressure falls rapidly, for capillary pressure is around 25 mm. Hg. Thus, a normal capillary pressure can be maintained in spite of great variation in arterial pressure, and the efficiency of the blood supply to the tissues need not suffer. Many individuals with systolic blood pressures of 100-110 mm. Hg. experience no untoward effects. Indeed, in the mass, low blood pressure distinctly favors longevity. These facts and the lack of correlation between variations in pressure and symptoms makes it difficult to assign to hypotension a primary role in hypasthenia. If a definite postural hypotension can be demonstrated, with a fall in both systolic and diastolic pressures on assuming the erect posture, the possibility of a hypersensitive carotid sinus reflex, central nervous system syphilis, or a tumor at or near the bifurcation of the carotid should be entertained.

ENDOCRINE HYPOFUNCTION

Hypofunction of one or another of the endocrine glands has frequently been invoked as a cause of hypasthenia. Indeed, the same symptoms are attributed to mild degrees of both hypo- and hyperthyroidism. But it must be remembered that our estimations of basal metabolic rate are based on average values for a given surface area and age, and do not take into account the variations encountered among normal active people. Minor deviations of the basal metabolic rate, in the absence of characteristic changes in appetite, weight, heat tolerance, etc., do not justify a diagnosis of abnormal thyroid function.

The presence of asthenia in Addison's disease has raised the question whether the milder symptoms of hypasthenia may not be due to milder degrees of adrenal insufficiency. But as Paschkis and Price[4] have pointed out, the diagnosis of "mild hypoadrenia" on clinical impression and the results of substitution therapy are unsatisfactory. They attempted to determine whether a more accurate diagnosis could be made on the basis of chloride excretion or

glucose tolerance tests. More asthenic patients than controls showed abnormally high excretions of Na and Cl and flat sugar curves. But on repetition of the tests normal values were frequently obtained without any change in symptoms. The authors conclude that while their results may be interpreted as indicating adrenal cortical involvement in some cases of asthenia, it does not follow that this is the cause of the symptoms. The considerable variation of the tests on repetition militates against the assumption of any organic disease, and the lack of correlation with symptoms makes it unlikely that even a functional or transitory insufficiency is the cause or main factor in the patient's suffering. They believe rather that the cause of metabolic changes is to be sought in an "unstable personality," manifest in the psychological sphere as a neurosis and in the somatic sphere in various ways, including the secretion of hormones.

Hypasthenia is a well-recognized consequence of certain infectious diseases and surgical operations. It is characteristically more pronounced after some infections than others, notably influenza, typhus, and meningitis. The patients usually feel pretty well in the morning, but tire quickly, are weak and irritable. It seems perfectly reasonable to assume that cellular function, enzyme systems or other intimate processes of cellular activity, may not recover from the damage inflicted by a hostile parasite synchroneously with the disappearance of the invader. But in addition, there is frequently considerable anxiety at this time. The patient has been through a threatening experience, his doctor and friends have congratulated him on his recovery, and yet he has not recovered. Has some hidden infection been overlooked? Will he ever feel "normal" again? Or is this the beginning of the end, like Bill Jones who has never done a day's work since the influenza in 1918 or Mrs. Smith who has never recovered from that appendectomy ten years ago?

Usually simple explanation and reassurance will allay the anxiety; and good food, fresh air and a little more time will complete the cure. In those patients who do not make progress, and in whom symptoms persist in fluctuating intensity, it is well to consider whether the illness has not been the precipitating factor in bringing out suppressed hostility, guilt or anxiety. Those diseases in which persistent structural damage accounts for hypasthenic symptoms, as encephalitis, hepatitis, myocarditis or even brucellosis, usually present definite evidence on physical examination or laboratory test. Where these are not apparent some time spent in listening to the patient, learning something of him as a person, and perhaps consultation with a psychiatrist, is apt to be more effective in preventing chronic invalidism than an empirical succession of tonics, vitamins, or hormones.

CONSTITUTIONAL INADEQUACY

Another group of patients who make the rounds of our offices is made up of those whom Alvarez[5] characterizes as constitutionally inadequate. They give a long rambling story of many ills, prolonged incapacity from minor illnesses, lack of physical stamina, and a variety of treatments with no lasting relief from their fatigue, weakness or pains.[6] Frequently they are of an asthenic build, with a body poorly proportioned and as if poorly put together. Yet they do not look sick, and are relatively free from symptoms in an environment shielded from physical and emotional stress. The neurocirculatory asthenias or effort syndromes who were such a problem in both World Wars, and are by no means uncommon in civilian practice, are examples of this group.[7]

Certainly not all "normal" people can stand the same amount of physical and emotional strain. The question is whether these patients are simply on the poor side of a normal distribution curve, or whether they are "pathological." Some have hypoplastic cardiovascular symptoms, an abnormal increase in blood lactic acid for a given amount of exercise, and an inefficient respiratory mechanism. Their performance cannot be significantly improved by training. Does this mean that they are poor protoplasma, that the hand of the potter slipped? Students of these people in the army in the last war came to the conclusion that the majority of them were essentially psychoneurotics with a deep sense of insecurity, perhaps resulting from early environment. In a protected atmosphere they are free from symptoms but are unable to cope with either average physical or emotional stress. Whatever the essential etiology, they are a difficult group to treat and the prognosis for any real improvement is poor. Tonics, hormones, vitamins, sedatives, and operations give no lasting benefit. The more physicians these patients visit, and the more often hope is raised by a "new" treatment, only to be dashed again, the more firmly they naturally become convinced that they have some hidden, obscure, and probably incurable disease. Barring possible benefit from prolonged psychotherapy, the only sensible and practical way to handle these patients seems to be to adjust their environment, reducing the strain to the level at which they are symptom free. This requires sympathetic understanding, and an attempt to explain that not all people, any more than all horses, can do the same amount of work. That unfortunately they have taken on more than they can do. That they have no demonstrable organic disease, no infection or tumor which is going to shorten life. That if they want to be free from symptoms they will have to curb financial or social

ambition, and be content to be a pawn rather than a knight in this game of chess, but with the assurance that "they also serve who only stand and wait."

PSYCHONEUROSES

Finally, there is the group of hypasthenics which made up 80 per cent of Allan's series, whose symptoms are due to "nervous" or emotional states. The points in the history of the weakness, fatigue, depression and discouragement which are characteristic of an emotional etiology have already been mentioned. These patients can be divided into two groups: those whose symptoms are of relatively short duration, and began during a definite period of overworry, not work, tension, uncertainty or anxiety; and those whose asthenia goes back for years, often to childhood, with periods of exacerbation and remission. In the latter there is frequently a family history of "nervous breakdowns," and often such obviously nervous symptoms as a lump in the throat, inability to take a satisfactory breath, or accentuation of symptoms in church or when shopping.

Relatively few of these patients, particularly of the first group, need psychiatric consultation. Not every patient with a running nose is sent to an otolaryngologist, nor every one with a murmur to a cardiologist. Moreover, frequently psychotherapy is inadvisable even if it were available. Not all wounds heal more rapidly if probed, and probing into the mechansim of an acute emotional reaction, precipitated by certain circumstances may delay rather than hasten relief. In this first group, reassurance that symptoms are not due to organic disease, a chance to tell his story, a sympathetic ear to receive a recital of fears and worries, and confidence that the physician understands what is the matter, even if the patient does not, is more effective than a succession of prescriptions. Such a chance to talk often enables the patient to see for himself the relation of his situation to his symptoms. With correction of the environmental trauma symptoms usually disappear. Direct advice as to change in business, social or family relations, however, must be given with the greatest caution. It is frequently rejected, and if accepted and unsuccessful the physician is blamed. Such changes must be made by the patient as he himself comes to realize their necessity. But during this period, it is helpful to prescribe in detail many nonspecific measures—hours of sleep, regularity and character of exercise, advice about diet, even when there is no evidence of deficiency. While the use of sedatives has come to be looked upon with disfavor in some quarters, they can frequently be used with great benefit if judiciously prescribed. Phenobarbital in small doses is usually better than bromides and one of the short acting barbiturates for insomnia. The patient should understand that these are not curative, but in the nature of a crutch which he must only use until he is able to get along without them.

The second division of this psychoneurotic group, those who have had symptoms for years, is without doubt the most difficult group to handle or help. With such a patient our first objective should be that of the old but still virile admonition "primum non nocere"—above all do no harm. This means, among other things, not treating for fallen womb one month, and vitamin deficiency, anemia, glandular dyschenesia and allergy on successive visits. The first step, of course, is thorough routine physical and laboratory tests. Next is sufficient time to get to know the patient, and to form an opinion of the relative importance of discoverable organic disease and emotional factors in the production of symptoms. These people cannot be helped by production line, or compulsory health insurance medicine. They need time and hard work. They are not financially profitable. I am not a psychiatrist, either by training, ability or philosophy. I have never cured one of these patients. But I do not know any greater satisfaction than seeing one gradually lose symptoms, take his or her place, though perhaps haltingly, in the family or social group, and pay fewer and fewer visits to the office. The first essential to accomplish this is to be a good listener and to appreciate the advantage of silence. If the doctor can keep quiet, as a rule the longer the silence the more significant the explosion of the patient at the end of it. I think the next most important point is to keep from giving direct advice, or expressing approval or condemnation. I do not think the psychiatrists give enough credit to Socrates for their techniques. You remember he never expressed his own opinion, but was very skillful in asking an apparently innocent question which would make his pupil scrutinize what he had just said. In those who are helped, as a rule neither doctor nor patient understand the dynamics of the symptoms, but a good rapport, a feeling that there is some noncritical confidant, assurance that organic disease has not been found, and a dim vision of the effects of anger, fear or other emotions on physical symptoms is sufficient to permit the patient to suppress or otherwise handle his problem, and so to lead a more normal life.

Some of these patients, particularly those with obsessive-compulsion reactions, marked depression or suicidal thoughts need expert psychiatric help. But even here we have an important role. You can lead a horse to water, and you can send a patient to a psychiatrist, but unless he goes willingly, even eagerly, he might just as well save his money. Therefore, before referral, we must spend enough time, at-

tempt enough explanation, build up enough hope so that he goes willingly. The psychiatrist will not promise cure, but I think the chances of relief are greater and the total cost no more than a hysterectomy.

SUMMARY

In summary, the patient who complains of hypasthenia presents a difficult diagnostic problem and one which in general is poorly handled. In a small percentage the symptoms of weakness, fatigue and loss of efficiency presage organic disease. These can usually be identified by careful physical examination and relatively few laboratory tests. When the symptoms are due to prolonged convalescence the history usually furnishes the clue. In the majority of these patients no organic cause for the symptoms can be found. Some are acute situational reactions in which the prognosis is good, explanation and reassurance the most effective therapy. Those in whom symptoms are of years' duration, or date from childhood, present the most difficult therapeutic problem. Some may be constitutionally inferior, others are frankly psychoneurotic. In spite of this, considerable relief of symptoms may be obtained by superficial and supportive therapy by the wise physician.

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Contact Dermatitis Due To Cinnamon

Unusual cases of contact dermatitis, although reported already in uncountable number, still merit attention, particularly when the contact proves to be a commonly utilized foodstuff. Failure to recognize the possibility of simple foods as external irritants may prolong a simple contact dermatitis into irreversible lichenified eczema.

REPORT OF A CASE

S. B., a 59-year old white female baker, with a non-allergic background, presented herself October 26, 1949 because of a severe erythematopapular eruption of both hands. The fingers were swollen, and intermingled with acute vesicular lesions were seen chronic lichenified areas on the dorsum of both hands. The dermatitis was extremely pruritic, and involved in ascending fashion both wrists and forearms. The palmar aspects of the hands were also involved, but to a lesser extent than their dorsal aspects. The skin was otherwise entirely negative including the absence of past or present evidence of fungus infection of the feet.

History revealed chronic dermatitis of the dry eczema type of the hands for two years, with frequent remissions and exacerbations, the latter definitely tied up with longer hours at work and holiday baking.

A diagnosis of occupational dermatitis was made and the patient was advised to bring in samples of foodstuffs she used in baking. Flour, shortening, liquid soap and cinnamon were applied as patch tests. Shortening was applied full strength, but the flour, soap and the cinnamon were diluted with equal parts of water. Within 15 minutes of application of cinnamon the patient complained of a definite burning itchy sensation beneath the patch. No such reaction occurred with the flour, shortening or liquid soap. The cinnamon patch was removed while the patient was still at the office, and a tentative diagnosis of cinnamon sensitivity was made. It was felt that the skin was generally quite reactive yet, and perhaps cinnamon diluted one-half and one-half in water was not a fair test at this time. The patient was advised to remain home from work, and was put on wet boric acid compresses and boric acid ointment. Soap was interdicted. On return to the office after two days for a reading on the flour, soap and shortening tests, all of which were negative, a small area of erythema still remained where the cinnamon had been applied. The patient made an uneventful recovery and returned to work after ten days, but avoided cinnamon entirely.

On February 2, 1950, about six weeks after complete subsidence of all symptoms, the patient was asked to return to this office for another patch test to cinnamon. A small batch of cinnamon was diluted 1 to 3 parts of water and applied as a patch test to the flexor aspect of the upper arm. The patient returned in twenty-four hours for a reading, and on removal of the patch a very definite erythema and beginning vesiculation was apparent over the site of the test. There could be no question of reactivity to the cinnamon. As controls, my office secretary and I each applied 50 per cent cinnamon in water to our arms as a patch test, which was left on for forty-eight hours. No reaction occurred. Of interest is the fact that cinnamon taken orally by the patient caused no local or systemic distress.

SUMMARY

A case of contact dermatitis of the hands due to cinnamon is reported in a 59-year old baker with a history of dermatitis for two years. During this length of time recurrent exposures to an unsuspected food spice resulted in chronic repeated irritation of the skin with resultant eczematous changes. Removal of the source of irritation resulted in speedy uneventful return of the skin to normal.

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The Treatment of Thrombo-Embolic Disease

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THE thrombotic or embolic occlusion of various strategically located vessels, e. g., coronary or pulmonary arteries, has long been recognized as a leading cause of death. Recent studies have shown that 50 per cent of all patients confined to bed have venous thrombi in the deep veins of their legs.[1] Studies have shown also that about 3 per cent of all deaths are due to pulmonary embolism. The importance of these observations has been greatly augmented by the recent discovery of specific methods of prevention and therapy of thrombo-embolic disease, namely, the use of venous ligation and the anticoagulants heparin and dicumarol.

The problem of treatment of thrombo-embolic disease will be considered according to the following outline.

1. Definitive treatment of venous thrombosis and pulmonary embolism.
2. Symptomatic therapy of pulmonary embolism.
3. Anticoagulant therapy in patients who have rheumatic heart disease and embolism.
4. Treatment of arterial embolism.
5. Management of superficial thrombophlebitis.
6. Treatment of coronary thrombosis.

The definitive therapy of venous thrombosis and pulmonary embolism may be discussed under the following headings.

1. Venous ligation.
2. Heparin alone.
3. Dicumarol alone.
4. Heparin and dicumarol combined.

Since at least 75 per cent of pulmonary emboli arise from deep leg vein thrombosis, the therapy of pulmonary embolism will be here considered as similar to that of deep venous thrombosis.

VENOUS LIGATION

Allen, Linton, and Donaldson[2] and Linton feel that either leg vein thrombosis or pulmonary embolism are indications for ligation of the femoral vein. These authors reported 464 cases in whom ligation had been performed. None died of the operation and only three died of subsequent pulmonary emboli. There was only one patient who developed postoperative phlegmon and leg ulcer.

Veal and Hussey performed venous ligation among 84 cases of deep venous thrombosis of the leg. There were no operative deaths. There were nine pulmonary emboli subsequent to the operation; three of these were fatal.

Ochsner favors bilateral ligation of the femoral vein as the treatment for phlebothrombosis. He thinks that ligation should not be done for thrombophlebitis unless it is suppurative.

Carlotti reported the results of femoral vein interruption done for pulmonary embolism in 60 patients on the medical wards of the Massachusetts General Hospital. The ligation was unilateral in many instances. Death occurred in 28.3 per cent of the patients. Among 213 similar patients who had no operation, the mortality rate was 50.7 per cent.

Fine and Starr consider anticoagulants useful, but dangerous because of the likelihood of hemorrhage following their use. These authors believe that pulmonary embolism of undetermined site of origin and venous thrombosis limited to the area below the knees should be treated by ligation of both femoral veins above the profunda.

HEPARIN TREATMENT

We shall now consider the therapy of deep venous thrombosis and pulmonary embolism by means of heparin alone. In 1946, Bauer reported the results of heparin therapy in 209 cases of venous thrombosis. Only three deaths occurred—a mortality rate of 1.4 per cent. Among 264 cases of deep venous thrombosis treated conservatively, there were 47 fatal pulmonary emboli—a mortality rate of 18 per cent. The only complications were hematuria in three cases and mild hemarthrosis without residua in two instances. The heparin treated cases of deep venous thrombosis were followed up to three years. The incidence of postphlebitic edema, induration, ulceration and leg pain was markedly reduced.

Murray prefers anticoagulant therapy to venous ligation for the following reasons: The

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manifestations of hypercoagulability are generally widespread and not localized to the area of the thrombus; it is difficult to define the area involved by the thrombus; even if the area involved can be defined, it is often impossible to be certain how high the thrombus has extended; a pulmonary embolus which is not immediately fatal may gradually produce death by thrombosis extending from the site of embolism. Murray treated 386 patients who had venous thrombosis by means of heparin. None developed pulmonary emboli. The incidence of post-phlebitic edema, ulceration and varicose veins over a nine-year period was greatly reduced. Murray gave heparin by continuous intravenous drip in such a manner as to keep the clotting time at 15 minutes. If the patients were able to be up within a week, the heparin was administered for three to four weeks.

Zilliacus[3] reported the treatment of 576 cases of venous thrombosis with heparin. Only three of these patients had fatal pulmonary emboli after the heparin was begun. Of 214 patients who received conservative therapy for the same disease, 20 developed subsequent fatal pulmonary emboli. The incidence of post-phlebitic ulcer, swelling, and varices was much smaller in the heparin treated group, but only among those in whom heparin was begun prior to the extension of the thrombus into the thigh. Zilliacus also reported 103 cases of pulmonary embolism who were treated with heparin; there were no deaths in this group. Sixty-five patients who had pulmonary embolism received no specific therapy; of these, 21 died.

DICUMAROL THERAPY

Barker[4] has given dicumarol alone to a total of 1,983 postoperative patients. Of these, 352 had venous thrombosis and 329 had pulmonary embolism. Among the patients suffering from venous thrombosis, subsequent thromboses were reduced from an expected 25.3 per cent to 2.8 per cent and fatal emboli from an expected 5.7 per cent to none. Among the patients suffering from pulmonary embolism, subsequent emboli were reduced from an expected 43.8 per cent to 1 per cent and fatalities were reduced from an expected 18.3 per cent to 0.3 per cent.

COMBINED TREATMENT

Heparin and dicumarol are often combined in the treatment of venous thrombosis and pulmonary embolism. Wright and Foley[5] recommend treatment of either venous thrombosis or pulmonary embolism by means of immediate heparin and dicumarol therapy; the heparin is discontinued after the prothrombin time falls to 20 per cent, indicating adequate dicumarol effect. The patient, if asymptomatic, is got out of bed after a week, and the dicumarol is discontinued after two weeks.

Jorpes reported favorable results of anticoagulant therapy in 576 patients who had deep venous thrombosis; in his group, some received heparin, some dicumarol, and some received both.

We should now like to consider heparin and dicumarol with regard to their dosage, method of administration, and contraindications.

The dose of heparin is regulated by its effect on the clotting time. Heparin may be administered in one of four ways.

1. In a menstruum of gelatin and dextrose as Heparin/Pitkin Menstruum[6] or as Depo-Heparin. By this method doses of 200 to 400 mg. of heparin are given subcutaneously every twenty-four to forty-eight hours.

2. Intermittent intravenous injection—50 to 75 mg. every three to four hours in 50 to 100 cc of saline. Here the clotting time should be 15 minutes or more two and one-half hours after each dose of heparin.

3. By constant intravenous drip, using 100 mg. of heparin to 1000 cc of normal saline; the drip runs at approximately 25 drops a minute; the rate of flow is adjusted so as to keep the clotting time between 20 and 40 minutes. The clotting time is determined every two hours.

4. Intermittent subcutaneous or intramuscular injection. This method has been described by Walker, and by Walker and Rhoades. Undiluted heparin, i. e., 5 cc containing 50 mg. may be given subcutaneously or intramuscularly every four to six hours.

The dose of dicumarol is regulated by its effect on the prothrombin time. The primary action of dicumarol is a selective inhibition of prothrombin formation by the liver. Its action is temporary, and other functions of the liver are believed to be unaffected, even by its long use. Dicumarol is given orally; its action begins in twelve to seventy-two hours and lasts seventy-two hours or longer after its discontinuation. The Quick method of prothrombin time determination has been described as the only accurate measure of dicumarol effect.* The prothrombin time should be kept between 10 and 30 per cent of normal by dicumarol therapy; most major bleeding from the use of dicumarol occurs when the prothrombin time is less than 10 per cent of normal; some patients will develop thromboses if the prothrombin time is allowed to rise above 30 per cent of normal.

Dicumarol therapy is not begun until a prothrombin time has been done and found normal. The patient is then given an initial dose of 300 mg., followed by 100 or 200 mg. the second day and then 50 to 100 mg. daily thereafter. It is to be emphasized that the daily dose of dicumarol is to be administered only after the

* Note: Some authorities now feel the two-stage method of determining prothrombin time to be more accurate.

prothrombin time has been determined for that day.

When heparin and dicumarol are used together, a more rapid effect on the clotting mechanism is obtained than if dicumarol is used alone. When heparin is given intravenously, the maximum effect on the clotting time is obtained in 10 minutes, the effect persists for one and one-half to three hours. Heparin should be administered by one of the methods described above; dicumarol is begun concomitantly. When the prothrombin time has fallen to 20 per cent of normal or below, the heparin is discontinued and the dicumarol is given as usual.

CONTRAINDICATIONS TO ANTICOAGULANT THERAPY

We should now like to list some of the contraindications to anticoagulant therapy. Wright felt that anticoagulants should not be used in the event of recent operation upon the central nervous system, subacute bacterial endocarditis except in the case of arterial embolic occlusion, hemorrhagic blood diseases, recent threatened abortion, or in obstetrical cases within six weeks prior to delivery. He felt that care should be used in the presence of hepatic or renal disease, granulating wounds, or open ulcerations. Barker, et al., listed the following as contraindications to dicumarol; definite renal insufficiency, hepatic insufficiency or hepatogenous jaundice, subacute bacterial endocarditis, hemorrhagic blood diseases, purpura, and recent operation on the brain or spinal cord. In contrast to the views of Wright, Bauer felt that there are no absolute contraindications to heparin.

MANAGEMENT OF OVERDOSE OF ANTICOAGULANTS

We should now like to consider the methods of combating the results of overdose of heparin or dicumarol. Serious bleeding is seen infrequently as a result of anticoagulant therapy if the proper precautions are observed. Barker gave dicumarol to 1,983 postoperative patients; only four died while receiving dicumarol. Two deaths were not due to the drug. Wright had no deaths among 800 patients treated with dicumarol. Bauer had no serious bleeding among 209 patients who were treated with heparin.

During dicumarol therapy, if the prothrombin time falls below 10 per cent of normal on two successive days, the patient should be given 30 mg. of synthetic vitamin K intravenously. If bleeding occurs during the administration of dicumarol, 64 mg. of vitamin K should be administered intravenously immediately and again in four hours. If there is no benefit in 12 hours, the patient should receive 300 to 500 cc of fresh citrated blood. The dicumarol is, of course, temporarily discontinued.

Bleeding during the administration of heparin may be treated as follows. The heparin is discontinued. Protamine sulfate, 50 to 100 mg., given intravenously as a 1 per cent or 2 per cent solution will return the clotting time to normal within five minutes.

SYMPTOMATIC TREATMENT OF PULMONARY EMBOLISM

DeTakats has described the symptomatic therapy of pulmonary embolism. He recommends that cases of massive pulmonary embolism be treated so as to combat the reflex bronchial and pulmonary arterial spasm which is often seen. The patient should be placed in a semi-sitting position and given oxygen. Atropine, 1/75 grain, is given hypodermically by a nurse. When the physician arrives, 1/60 to 1/75 grain of atropine is given intravenously, and 1/2 grain of papaverine is given intravenously. The atropine and papaverine are repeated three to four times daily. Of 45 patients receiving this treatment, 35 did not die of that attack. DeTakats felt that patients who have had massive pulmonary embolism and who develop right-sided heart failure during the ensuing few days, should be considered candidates for embolectomy.

A recent use of anticoagulant therapy is in the treatment of patients who have rheumatic heart disease with auricular fibrillation and repeated peripheral emboli. Sprague and Jacobsen have treated one such ambulant patient for 15 months without incident or recurrent embolization.[31] Wright[32] has treated 22 such patients without the occurence of any emboli during the time of therapy. Six of Wright's patients have been treated for a year or more.

MANAGEMENT OF ACUTE ARTERIAL OCCLUSION

Acute arterial occlusion, whether thrombotic or embolic, is an indication for anticoagulant therapy. Heparin and dicumarol[15] or heparin alone[33] may be used. Anticoagulants should be given as soon as the diagnosis is made, and certainly within twenty-four hours of the occlusion with the idea of preventing secondary thromboses and gangrene. Survival of the affected extremity was achieved in 10 of 11 patients with arterial embolism and in 13 of 16 patients with arterial thrombosis who were treated with anticoagulants.

ANTICOAGULANTS IN ACUTE MYOCARDIAL INFARCTION

The anticoagulant therapy of acute myocardial infarction has been a topic of increasing interest during the past few years. In 1946, Peters reported a mortality rate of only 4 per cent among 50 patients suffering from coronary thrombosis who had received dicumarol therapy; among 60 controls taken from previous cases of coronary thrombosis at the same hospital, the mortality rate was 20 per cent. The incidence of embolism among the treated group

was 2 per cent, and among the untreated group, 16 per cent. In 1946, Wright also reported 76 patients who had had myocardial infarction and who were treated with dicumarol. The mortality rate in his group was 19 per cent, but only cases with a poor outlook were treated. There were no controls in this group. In 1947, Nichol reported the dicumarol therapy of 62 patients representing 68 attacks of coronary thrombosis. The mortality rate was 12 per cent. In 1947, Parker and Barker treated 50 patients suffering from acute myocardial infarction by means of anticoagulants. A group of similar cases seen in 1945 were used as controls. The treated group had only one-fourth as many vascular complications as the control group, but the mortality rate was not significantly different in the two groups. In 1948, Glueck, et al., reported the treatment of 44 patients suffering from myocardial infarction by means of heparin and dicumarol combined. In the treated group, 20 per cent died and 7 per cent had complicating thrombo-embolism. In 44 untreated controls, 45 per cent died and 27 per cent had complicating thrombo-embolism. Also in 1948, Wright reported the results of anticoagulant therapy in 800 cases of myocardial infarction treated in several hospitals.[7] The over-all mortality rate in the treated group was 15 per cent; in the control group, the over-all mortality rate was 24 per cent.

SUPERFICIAL THROMBOPHLEBITIS

Superficial postoperative, postinfectious, or posttraumatic thrombophlebitis require anticoagulant therapy. The other types of superficial thrombophlebitis do not require anticoagulant therapy unless complicated by pulmonary embolism.

SUMMARY AND CONCLUSIONS

The existence of either deep venous thrombosis or pulmonary embolism is a definite indication for either venous ligation or anticoagulant therapy. It is felt that anticoagulant therapy is to be preferred to deep venous ligation unless one of the following conditions is present: suppurative thrombophlebitis; definite contraindications to anticoagulant therapy; repeated pulmonary emboli despite adequate anticoagulant therapy; unavailability of laboratory facilities adequate for anticoagulant therapy. It is also felt that anticoagulant therapy should be initiated with heparin and dicumarol; the heparin is discontinued after the dicumarol has become effective. Patients suffering from massive pulmonary embolism should be treated so as to combat reflex bronchial and pulmonary arterial spasm. Patients suffering from acute peripheral arterial occlusion, whether thrombotic or embolic, should receive anticoagulant therapy. Patients suffering from rheumatic heart disease and repeated peripheral arterial emboli may benefit from constant ambulatory anticoagulant therapy. The mortality rate among patients suffering from acute myocardial infarction can probably be lowered by the use of anticoagulant therapy for four weeks.

The use of anticoagulant therapy in cases of deep venous thrombosis of the lower extremity not only decreases the incidence of pulmonary embolism, but also diminishes the likelihood of such post-thrombotic sequelae as dependent edema, varices, leg ulcer, and chronic venous insufficiency of the limb.

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The Story Behind the Word

Some Interesting Origins of Medical Terms

Impetigo—This common skin disease is so called because of its contagious nature. It is derived from the Latin word "impeto," I attack. It is mentioned by Celsus in his book De Medicina written about A. D. 30.

Licorice or **Liquorice**—This substance has been used medicinally since ancient times and was recommended for the treatment of sore throat by Dioscorides a surgeon in Nero's army. The term literally means "sweet root" and is a corruption or contraction of the Latin term "glycyrrhiza." This in turn is derived from the Greek words "glukas," sweet, and "rhiza," root.

Trachea—A term of ancient Greek origin literally meaning the "rough windpipe." It is derived from the Greek word "trachus" meaning rough, it being understood that the "ea" ending comes from the Greek word "arteria" or artery which literally means a windpipe.

Bougies—These flexible instruments for urethral exploration which are now usually made of woven silk and varnished, were at first made of wax or elastic gum. Medically we borrowed the term from France where the word "bougie" signified a wax candle and was so named from the town of Bougie in Algeria.

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The Use of CO_2 in Inhalation Therapy

ADOLPH SHOR, M. D.

THE physiological basis for therapeutic use of CO_2 lies in the fact that CO_2 is the most powerful respiratory stimulant known. Normally the tension of CO_2 in the body fluids is maintained within narrow limits. This relationship may be upset temporarily by administering additional CO_2, but unless the added load is overwhelming in amount, the organism will rapidly excrete the excess.

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THE PHYSIOLOGY

With an excess of CO_2, the following results rapidly occur:

1. The respirations increase both in rate and depth. If the normal alveolar CO_2 tension of 40 mm of Hg., is increased by 1.5 mm of Hg., the respiratory minute volume will be doubled.
2. There is increased bronchial peristalsis, increased ciliary function and hyperemia of the bronchial mucosa.
3. There is a rise in the systolic blood pressure, with a peripheral vasoconstriction but a cerebral vasodilatation. Therefore, the vital central nervous system has an increased blood supply.
4. The distensibility of the myocardium is increased, yielding a greater filling and greater output of the heart.
5. The tonus of the skeletal muscles is increased, enhancing the venous return to the heart.

Miescher in 1885 showed, by experiments with man, that additional CO_2 in inhaled air will result in increase in respiratory exchange. In 1924 Yandell Henderson did much to advance the widespread use of CO_2 as a therapeutic agent. Examples of those conditions where CO_2 may be given with value are:

1. Asphyxia as in CO poisoning.
2. Hiccough of persistent nature.
3. Unproductive cough as in bronchitis, bronchiectasis, unresolved pneumonia, etc.
4. Postoperative atelectasis—prophylaxis and treatment.

In CO poisoning, the value of CO_2 lies not only in its ability to increase respiratory ventilation, but as Haldane and others have shown, the affinity of hemoglobin for CO is decreased by the presence of an excess of CO_2. The treatment consists in the immediate administration of O_2 containing 5 to 10 per cent CO_2. If the respirations are shallow or absent, artifical respiration is indicated. Here the oxygen is the essential element of treatment; however, the addition of a small amount of CO_2 to the inhaled gas speeds the recovery period.

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In asphyxia neonatorum most authorities agree that artificial respiration with oxygen is the treatment of choice. In those infants who have had artificial respiration and have begun to breath without assistance but whose respiration does not appear to be wholly satisfactory, with a possibility of some atelectasis persisting, carbogen with a CO_2 content of not more than 5 per cent may be given. Here the administration must be stopped as soon as the desired effect is noted, for any prolonged exertion will exhaust these patients.

In persistent hiccough CO_2 may be given with oxygen or with air. In some cases 5 per cent CO_2 will terminate the hiccough within a couple of minutes, in other cases or even in the same case at a different time, this concentration will be found to be ineffective.

However, if higher concentrations of CO_2 are given when lower concentrations do not help, it will be found that most cases of hiccough can be stopped by this treatment. Sometimes the amount of CO_2 necessary may be high enough to cause dizziness or even unconsciousness. Such high concentrations will not be harmful if hypoxia is avoided and the duration of treatment is not extended beyond two minutes in using CO_2 in air or five minutes in using CO_2 in O_2. The physiological factor involved is not the deep breathing per se, but the stimulation of the respiratory center and the relaxation which CO_2 in high concentration produces. It must be mentioned, however, that rarely causes of persistent hiccough are not benefitted by CO_2 whatever concentration may be used.

UNPRODUCTIVE COUGH

In the treatment of unproductive cough, the basis for the use of Co_2 lies in effects locally on the lung itself, as pointed out by Banyai in 1945, namely the hyperemia of the bronchial mucous membranes with increased ciliary function and increased production of mucous associated with an increased bronchial peristalsis and wider lung excursions.

It is in the prophylaxis and treatment of

postoperative atelectasis that CO_2 is most commonly used. With the widespread adoption of the stir-up regime in the past, the incidence of postoperative atelectasis has been greatly reduced, and the treatment of atelectasis has been greatly improved. As is well known, the stir-up regime consisted originally in having the patient turn, take deep breaths, and cough at frequent intervals. The main reason for adding CO_2 inhalations to the stir-up regime is rather obvious to anyone working in most hospitals today—namely the nursing problem. Even though the nurses try to enforce the stir-up regime, in many hospitals there are too few nurses to do a thorough job on the multitude of operative patients. For that reason, it has been found that administering CO_2 to the patient takes less time and results in more effective stirring of the patient than had been obtained heretofore. The need for additional oxygen, along with the CO_2 is minimal; therefore, although many men still prefer 5 per cent to 10 per cent CO_2 in O_2 many others now use CO_2 and air therapeutically in the prophylaxis and treatment of atelectasis.

THE ADVANTAGES

The arguments for the use of CO_2 in air are:

1. It is faster—the effect should be obtained within one minute—5 per cent in O_2 takes 15 minutes; 10 per cent in O_2 takes 5 minutes.

2. It is more efficient, frequently 5 per cent CO_2 in oxygen is not effective, and 10 per cent may be needed for as long as ten minutes. When the effect does occur, the terminal alveoli are filled with oxygen, thus are prone to become atelectatic in that the O_2 may be absorbed within a few minutes. When using CO_2 in air, the terminal alveoli are filled with air of which the nitrogen takes almost twenty-four hours to be absorbed; hence, after full expansion with oxygen, atelectasis can recur within minutes, after expansion with air atelectasis should not recur in less than a day.

3. It is easier to administer. All one needs is a small cylinder of CO_2 with a yoke and rubber connection. The gas is allowed to flow gently over the nose and mouth until the patient takes several deep breaths, then is discontinued. With carbogen (CO_2 in O_2) a large cylinder is necessary because so much gas is used.

4. It is cheaper, both in absolute cost of the individual gases and in total value required per patient.

DISADVANTAGES

The main argument used against employing CO_2 in air is that too high a concentration may be inhaled, resulting in anesthesia. However, when it is given, if several deep breaths only are taken by patient or if given for not more than one minute, it should not be harmful in any way.

The main problem involved in teaching others to give CO_2 in air is to prevent an overdose. If the patient is told to breathe deeply, then one cannot be sure when a sufficient amount has been given. For this reason the patient should be told to breathe normally and the inhalations are stopped as soon as he is seen to be breathing deeply. Sometimes patients cannot be taught not to help—that is, they try to breathe deeply from the start, and, because of this, it has been found wise to limit the time of inhalation to one minute to prevent overdose. The same problem occurs in giving carbogen by mask for there the administration is often started by the nurse, then forgotten, resulting in too-long exertion with exhaustion. When giving carbogen, the patient should be watched and the inhalations stopped as soon as the desired effect is obtained, just as when CO_2 in air is given. Sometimes a mistake is made, in which tank is used, and instead of 5 per cent carbogen, one may use pure CO_2. If this is given by mask, the result will, at best, be unpleasant for the patient—at worst may cause a fatality.

The uses of CO_2 therapeutically has been discussed; however, a word of warning concerning its dangers is indicated. As in the use of all drugs, the contraindications are relative in most instances, absolute in a few. Some conditions where CO_2 is definitely contraindicated are:

1. Pulmonary embolism.
2. Tendency to hemorrhage, pulmonary, gastric, etc.
3. Laryngeal stricture.

Some relative contraindications are:

1. Emphysema.
2. Hypertension.
3. Cardiac pathology.

In giving CO_2 to a patient for any reason, it must be remembered that the administration must be discontinued as soon as the desired effect is obtained, for the continued administration of CO_2 will result in the exhaustion of the patient.

SUMMARY

In summary, the use of CO_2 as a therapeutic agent has been reviewed. Its value in the treatment of asphyxia, persistent hiccough, unproductive cough, and atelectasis has been pointed out, with some mention being made of the basis for its use. Some of the major contraindications have been listed with definite warning as to the possibilities of occurrence of overdose.

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Full-Term Intra-Abdominal Pregnancy

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THE following is a case report of an intra-abdominal pregnancy with a six-year follow-up.

This patient, Mrs. M. T., was a 34-year-old white female admitted to Cleveland City Hospital because of continuous abdominal pain and tenderness associated with pregnancy.

Her last menstrual period was March 24, 1942, and five months from her period the abdominal pain began insidiously. It was of a cramp-like nature, and somewhat more severe in the right lower quadrant. It was associated with nausea and the patient had vomited occasionally since early in pregnancy. There was one episode of vaginal spotting.

Physical Examination. Fetal heart rate 140 in left lower quadrant near midline. Blood pressure 110/60; pulse 84; temperature 37. Examination was essentially negative except abdomen showed 6½ months' pregnancy in transverse position. Head in the right flank and breech in the pelvis. A large tumor-like mass the size of a grapefruit was present in the anterior wall of the uterus, thought to be a fibroid, with lower pole behind the symphysis. It was felt that the tumor would cause distortion and probably degenerate before delivery, therefore a Caesarian section and myomectomy were recommended.

Laboratory Findings: Red blood count 3.65; hemoglobin 70 per cent; white blood count 6,200; urinalysis negative; Wassermann negative. X-ray report in October, 1942: AP and lateral films of abdomen and pelvis showed the presence of a fetus approximately 6½ months' gestation size situated with the back extending transversely across the abdomen with the head in right mid-abdomen. A poorly defined mass was situated in the right abdomen, which was thought to represent the fibroid described clinically.

The patient was discharged to be followed in the outpatient department. Her findings remained essentially the same except for progressively more severe lower abdominal pain marked in the right lower quadrant, partially controlled with codeine. One episode of pain sent her to the emergency room where the resident in obstetrics attempted an external version without success. She was also observed in the hospital for forty-eight hours because of this severe pain.

The patient was readmitted on December 18, 1942, because of near-term pregnancy and progressively more severe right lower quadrant pain. Physical examination was essentially negative except for the abdomen which revealed a pregnancy palpable to the level of four fingers below the xyphoid. The fetus was still in a transverse position with the head on the right and the breech on the left. Between the head and the symphysis lay a mass about the size of a grapefruit which seemed to be continuous with the uterus. Fetal heart rate 144 left of midline.

Laparotomy for transverse position and fibroid complicating pregnancy was performed on December 21, 1942. The abdomen was opened in layers through a sub-umbilical midline incision. There was no free peritoneal fluid. Examination revealed a uterus the size of a twelve weeks' pregnancy. Above the uterus was a smooth, large glistening sac to which the omentum and bowel were adherent and which was lying between the uterus and liver. The hair of the fetal head could be seen through these membranes. After freeing the omentum and bowel from the amniotic sac which seemed parasitic, it was ruptured and the fetus was delivered. The infant breathed spontaneously and the only abnormality was a torticollis of the neck. The membranes were then dissected free as far as possible from the surrounding intestine and omentum and amputated. The placenta was implanted over the bifurcation of the aorta and left *in situ* after amputating the cord as proximal as possible and ligating with chromic catgut. The peritoneal cavity was then cleansed of blood and clots and the omentum brought down and the abdomen closed in layers.

Postoperative Course. Temperature was not elevated beyond 37.8 degrees C. The wound healed per primum. The patient complained of persistent lower abdominal heaviness and irregular vaginal bleeding which was at no time excessive.

Six weeks' postpartum pelvic examination revealed a full, slightly tender cul-de-sac with slight tenderness in both lower quadrants. The patient was doing her work and leading a normal life. The baby was normal. Four months' postpartum examination revealed that menses had been established April 2, 1943, and were normal in character. Because of the persistence

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Submitted May 14, 1949.

of the pelvic mass a Friedman test was performed and found to be negative.

The patient was readmitted to the hospital on May 20, 1943, and operated for chronic cholecystitis with cholelithiasis. Because of her recent intra-abdominal pregnancy, a careful examination of the pelvis was made. A mass about 4½ inches in diameter and 1½ inches in thickness was palpated a little to the left of the midline lying over the bifurcation of the aorta. This mass was rather firm, reddish in color, and smooth. Attached to the mass were a few vascular adhesions but no small bowel. The fundus of the uterus felt normal but was slightly adherent to the mass. The hand could not be inserted posteriorally all the way into the cul-de-sac between the fundus and the placental mass. During palpation a few of the adhesions were broken and there was slight oozing in this region. The surgeon then proceeded with the cholecystectomy which the patient tolerated well.

On June 10, 1943, hystero - salpingograms showed the uterine body to be well outlined. The lower uterine segment was displaced to the right of the body of the uterus. The left tube and ovary were outlined and only a small segment of the right tube filled. Films of the pelvis made twenty-four hours following salpingograms showed radio-opaque material still present in the pelvis. She was discharged June 15, 1943, in good condition.

Dispensary visit on October 30, 1945, revealed a firm mass palpated through the cul-de-sac, nodular in shape, and not movable. Milk was expressed from both breasts. Since the patient complained of epigastric pain and abdominal distention, a gastro-intestinal series was done with the following conclusions: (1) No evidence of a pathological process involving the rectum, colon or terminal ileum. (2) No evidence of organic disease involving the esophagus, stomach, or duodenum.

The patient's last dispensary visit, six years after delivery, revealed a marital outlet with a moderate rectocele and a small cystocele. The cervix was posterior with a healed transverse laceration, freely movable and non-tender. The fundus was anterior and normal size for a multipara. There were no adnexal masses present.

In the posterior fornix was a very firm nodular fixed mass which was tender to palpation. The mass extended across the cul-de-sac; the size was undetermined because it could not be outlined throughout its entire extent.

No gastro-intestinal or genito-urinary symptoms were present, hence X-rays of these systems were not deemed necessary.

DISCUSSION

In Ronald Reid's review of 236 cases of intra-abdominal pregnancy in 1938, statistically:

1. The correct diagnosis preoperatively was made in only 35 per cent of cases.
2. Two hundred twenty-eight babies showed deformities, usually due to pressure.
3. Infant mortality rate in near-term infants was 35 per cent.
4. Maternal mortality rate was 14 per cent,—shock, hemorrhage and peritonitis accounting for the majority of deaths.

The persistence of the placental tissue with either degeneration and fibrosis or potentially a malignancy remains in the realm of possibility and can only be determined by a careful follow-up.

Incidence: In Sunde's series of 38 cases, 5 per cent of chorioepitheliomas were preceded by extra-uterine pregnancies.

Preston and Gay find 2.6 per cent of choriomata are preceded by an extra-uterine pregnancy.

P. Klein points out that the aggressiveness of the fetal cells can be observed during the normal implantation of the ovum but it is more pronounced in an implantation of the ovum in an unfavorable medium, especially in the tube. He found recorded in the literature 15 cases of chorioepithelioma in the tube following extra-uterine pregnancy.

Hellman and Simon state that, if the placenta is easily removable, its complete excision is mandatory.

Biological Tests: A negative biological test does not rule out chorioepithelioma. G. Tuchschund reported two cases of chorioepithelioma with a negative A-Z test for both urine and blood.

Time Element: In one of Novak's cases occurring in the fifty-third year, the last childbirth preceded the appearance of the chorioepithelioma by seventeen years.

SUMMARY

A case of full-term intra-abdominal pregnancy delivered by laparotomy with placenta left *in situ* and baby living and well is presented.

A six-year follow-up is included on this case.

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Galactosemic Cataract

Galactosemia is a metabolic disorder of infancy, characterized by the symptoms of inability to gain weight and lack of growth. The essential signs are those of hepatomegaly, splenomegaly, melituria, and albuminuria. In over half of the case reports the presence of a cataract has been mentioned, both nuclear and zonular changes having been described. No case report has yet, to the author's knowledge, been reported in the ophthalmological literature. It is the purpose of this paper to so present a case of galactosemia with associated cataract. The heredity of the disorder as well as a careful summary of the literature will be undertaken.

—Harold F. Falls, M. D.,
Ann Arbor, Mich.

Brief author's abstract of paper presented at charter session of the Association for Research in Opthalmology, East-Central Section, Jan. 10, 1950.

Hygiene of Pregnancy

ROBERT F. DALY, M.D.

IT is distinctly understood that this discussion will be limited to matters of hygiene. It seems to me that the best way to approach the subject is to mention some of the outmoded notions concerning it and to emphasize that one is never justified in going against folklore until there is no shadow of doubt that it is pure superstition. In most instances, it will be found to be a combination of superstition and truth.

To begin at the top, suppose we consider mental hygiene as our first point. Fear of pregnancy and complications has been thrust upon women throughout generations. Frequent reference to the suffering of women in labor is contained in the Bible and is carried on down to the present generation in some of the motion pictures of the present day. It apparently always is "open season" at the bridge table whenever a member of the club reports that she is pregnant, and this notice is the signal for each well-wishing fellow club member to relate the horrible and dire consequences of some particular case that she can relate to the prospective mother. Why women should treat one another like this is beyond my understanding, but it nevertheless is a fact.

At the other extreme there is in the popular pseudo-scientific literature of the ladies-home-literature variety, considerable evidence that childbirth is a great ecstasy and that anyone who indulges in the use of analgesics is more or less a quack. This too seems a little extreme, and I believe that there are certain cases which no doubt lend themselves to that degree of hypnosis or psychosomatic prophylaxis necessary, but certainly from a practical standpoint, the time necessary to make such a program effective is excessive in the case of the general practitioner or the specialist who is as busy as most of them are today. Certainly there is some conservative middle-of-the-road policy which may best be used, in which two things should be pointed out: one, that the woman who so desires at least can be assured of an effective analgesia which should leave her with a very satisfactory impression of the rigors of childbirth; two, that there are some women certainly who, with some encouragement, very well can approach pregnancy with somewhat less fear, and thereby be better patients to handle from a standpoint of the amount of early analgesia necessary, and thereby shorten the period of time during which said analgesics are required. There is no question that this is better on the average for the infant, and that it makes a shorter period of time during which the patient is more or less irrational and a strain on the nerves, particularly of the relatives. It is our place and duty to prepare the patient for the lying-in period and to stress the fact that this procedure has been normal for years and years, and that most cases have been terminated successfully and happily; that her expectancy of living is very excellent. During the prenatal period a little time spent on explaining some of the minor aches and pains on a normal basis and even of anticipating some of them, may well be worth while.

Mention might be made of the subject of maternal impression. The laity rather extensively still clings to an old belief that impressions and nervous symptoms of various sorts might be transferred to the baby. The mother should be assured that absolutely no connection exists between the mother and the child except at the placental site, and that this structure provides no nerve pathways by which such nerve impulses can be transmitted. There have been no clinical data whatsoever which would support a viewpoint that the child can be influenced in any way, for better or worse, by the mother's emotional reactions.

Proceding "southward" in our discussion, care of the eyes may be necessary during pregnancy. Many of the patients we are seeing never previously have been under medical care. These patients are not exempt from the problems of eyestrain or problems of refraction, and this fact should be borne in mind. The commoner symptoms of eyestrain should be watched for and if there are evidences of any of these symptoms, adequate refraction should be advised.

In regard to the nose during pregnancy, two facts come to mind that recur frequently during the course of events in pregnancy. First, I have seen women who had occasional or frequent nosebleeds for the first time in their personal histories during their antepartum period. Secondly, women who develop upper respiratory infections during the antepartum period un-

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Presented before the Section on Obstetrics and Gynecology, at the Annual Meeting of the Ohio State Medical Association, Columbus, April 19-22, 1949.

doubtedly show a prolonged recovery time. I believe that both of these situations are due to the same physiologic fact. Specifically, there is congestion of mucous membranes during pregnancy due to the altered physiology of the pregnant woman. This is a necessary factor in the proper nourishment of the growing fetus, but so too are the mucous membranes in other parts of the body congested. The latter simply are incidental to the over-all picture, but the nasal congestion probably is the precipitating factor, upon which a fragility of the Kesselbach's area of the nose may result in nosebleeds. The delayed recovery time in upper respiratory infections undoubtedly is a "catarrhal" condition—simply a congestion of mucous membranes of the nose which simulates a cold, but the membranes nevertheless may not be acutely or chronically infected. The treatment of these two situations should be cautery of the Kesselbach's area in the first case, and in the second case topical or local use of agents to reduce mucous membrane congestion. The ephedrine action of some nose drops should be borne in mind, in view of the possible influence on blood pressure, but we all know some agents in which ephedrine-like action is reduced or absent.

CARE OF THE TEETH

It has been our practice to encourage oral prophylaxis during pregnancy. Briefly the only factor worth mentioning in such an obvious situation is as follows. We personally believe that any radical procedure, whether it be care of the teeth or any other regulation of the conduct during pregnancy, should be considered in the following light: That minor procedures in the normal antepartum case certainly are of no dire consequence, but more extensive or more radical procedures very well may be delayed, if possible, until the second trimester of pregnancy. These cases always must be considered as individual ones, and the necessity of any surgical procedure must be weighed against the possible consequences. When there is a choice in the matter, we believe that in the care of the teeth, certainly oral prophylaxis and filling of teeth may well be done at any time during the pregnancy, but major procedures, including extraction, could well be delayed until the fourth month has been passed.

Approximately at six weeks of pregnancy the breasts become heavier and the veins more prominent. Frequently this is a source of discomfort. We feel that it is wise to apply a supporting type of brassiere to the breasts during the antepartum period. During the entire course of pregnancy, particularly in multiparae there is likely to be some secretion from the nipple which simply is an expression of secretory activity. If the secretions are allowed to accumulate and form a crust, the skin beneath the crust may become irritated, cracked and thereby become the portal of entry of infection. We advise all women during the last two months of pregnancy to spend some time in cleansing the nipple and in gentle stimulation of the nipple. If there is appearance of secretion prior to this time then we instruct them regarding cleansing the nipple at intervals frequent enough to prevent damage to the skin. During the last two months, cleansing twice a day with a mild soap, gentle but increasingly stimulating exercise during the drying of the nipples may well be advised to accustom the nipple to the stimulation it will receive in nursing and to develop what may have been an undersized or retracted nipple.

ABDOMINAL SUPPORTS

Regarding abdominal supports during pregnancy the primigravid woman who never has worn a girdle seldom requires one during pregnancy. If she has, through the course of years, become accustomed to the wearing of a girdle, it generally will be found that she will feel better and that she has made the use of a girdle necessary by coming to depend upon it. Those women who once have been pregnant have abdomens which are more or less like an old two-way-stretch girdle. In other words, once having been stretched by a full-term pregnancy the abdominal wall does not completely return to its former state, and such being the case, the second or third pregnancy will be more poorly supported, will "be carried lower" than were the previous pregnancies. This factor has long been one of grandma's criteria in predetermining the sex of the infant but is more reasonably explained in the light of support and the inefficiency of the postpartum abdomen. The low backache and the altered posture due to shifting the center of gravity usually will show beneficial response to the use of a supportive type of girdle.

In regard to the commonly called "feminine hygiene," we recommend that no douches and no enemas be taken during pregnancy. There occasionally may be some justifiable reason to deviate from this course, but as a general principle we feel that this is the proper recommendation.

In the care of extremities, the commonest problem arising during prenatal care is the problem of varicose veins. There are three methods of control of this situation: (1) elastic stockings or elastic bandages; (2) injection of the veins, with some escharotic substance; and (3) ligation with or without injection or stripping. This subject is one which could be discussed as a separate topic. We feel that any of the procedures are good; we feel that some cases require more drastic treatment than others; and we feel that even though more drastic, that ligation and injection or stripping frequently are necessary. This we admit is a

debatable subject and we are expressing our viewpoint as a purely personal opinion.

The use of restricting garters is unwise. This is true in nonpregnant state as well, but it is more dangerous during the pregnant state. The stockings can be supported by a loose garter belt, from a girdle support or from some of the special appliances which are designed to be suspended from the shoulders.

GENERAL PRINCIPLES OF EXERCISE, REST AND RECREATION

We feel that there should be conservatism in this regard. We express our viewpoint most often as follows: We feel that the woman during pregnancy should, with moderation, follow a pattern of exercise similar to that which she ordinarily pursues when not pregnant. In other words, if an athletic woman becomes pregnant she dare not become completely sedentary, and on the other hand the sedentary individual or the office worker need not become an athlete simply because she is pregnant. We think it unwise to indulge in violent exercise and we usually mention such things as bowling, swimming, badminton, pingpong, etc. Certainly walking and mild types of exercise in the open air are an aid to the pregnant woman's morale even though we do not feel that it is strictly essential to her well-being. Certainly no exercise beyond the point of very mild fatigue should be advised or permitted.

The problem of vacations and trips during pregnancy still is open to discussion before final decision can be reached. It was found during the war when women by necessity were forced to travel great distances and at considerable physical strain that the abortion rate was no higher than before or since. Again, however, we feel that conservatism in our advice is wise because no given patient in different pregnancies can be generalized in this regard and if abortion does ensue following trips which perhaps are unnecessary, I feel that we may have been unwise in allowing that. Any trip which is necessary may be permissible if the patient has evidenced no symptoms of threatened abortion.

SEXUAL INTERCOURSE DURING PREGNANCY

This problem always arises during pregnancy whether or not it is discussed by the patient and her physician. There might be an occasional exception but certainly they are not great in number.

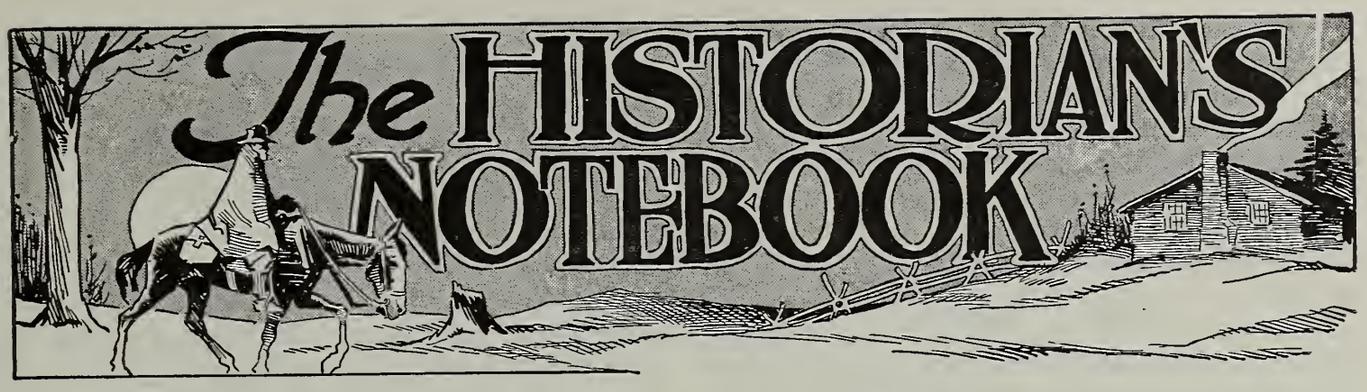
Inasmuch as it is probably going to occur during pregnancy perhaps by some modification of the time and method, we may thereby safeguard the patient's welfare. We feel that during the first four months of pregnancy that intercourse should be avoided during the so-called menstrual "anniversaries," the period of time when the patient would have been menstruating had she not become pregnant. After the fourth month if there is no cramping or bleeding, or other symptoms of threatened abortion, we feel that with gentleness intercourse is permissible; this permission is again withdrawn during the last two months of pregnancy.

In closing, I would like to mention two or three topics which frequently arise as questions from the patient, and our feeling on the questions. First of all we do not believe that raising the arms above the head can be harmful inasmuch as it seems very unlikely that the fetus will have any idea just what the anatomical relationship of its mother's arms to her body may be at any given time. We do not feel that he can respond by abruptly wrapping the cord about his neck. Secondly, we do not feel that the odor of turpentine from painting is dangerous unless it might be so strong or so obnoxous to the mother that she be made so ill by that odor that she vomit and retch so violently that she disturb the pregnancy physically.

In regard to stride gravidarum, or the so-called "stretchmarks" of pregnancy, we personally do not feel that it makes one iota of difference whether or not the average woman uses lubricating oils or grease during pregnancy on the skin of the abdomen and hips. We have seen all combinations of cases in which marks were or were not present in women who did or did not use some oil or grease. We generally take the attitude of permitting the use of these substances so long as the abdomen is not massaged too vigorously and that the oil may be pinched into the skin rather than rubbed in. We feel however that the influence of mothers-in-law is still a considerable factor and that for us deliberately to advise against the use of these oils is simply to add fuel to the fire when the stretch marks may appear.

The use of high heels during pregnancy:— As a matter of maintaining equilibrium in the presence of pregnancy with its shift of the center of gravity, we think it probably is a wise practice to advocate the use of lower or flat heels on shoes. This is not an absolute necessity at all times, however, and we do permit our patients to wear high heels for dress occasion, and in walking short distances where they will not grow too tired from the muscular strain necessary to maintain balance. We feel the greatest danger of high heels probably is in their insecurity and not in any great shift or exaggeration of the hyperextension of the spine during pregnancy.

Climbing up on stepladders and chairs to do household duties is a dangerous practice because of the instability of balance of a pregnant woman. The danger is not from the excessive altitude but in the consequences should she fall, and she is more likely to fall from these perches when she is pregnant.



Culture Is Based on History; and History Is Based Upon the Written Word

PART II

(Concluded from the June Issue)

JONATHAN FORMAN, M. D.

CERTAINLY one of the outstanding achievements of Science for the Art of Medicine was the production of the modern X-ray machine. The first person to be burned by the rays which emanated from the Crookes tube was Emil H. Grubbé, M. D., of Chicago. It was his burns that suggested the use of X-rays for the treatment of disease and so he became the first person to use them for this purpose. It is eminently fitting, therefore, that Dr. Grubbé should give us the story of **X-Ray Treatment, Its Origin, Birth and Early History** ($3.00. *The Bruce Publishing Co., St. Paul, Minn.).* In addition to his own contribution, the author has assembled a list of martyrs—victims of X-rays.

SIR ARTHUR HURST

One of the British physicians whose writings I always have followed and enjoyed at a great personal profit, has been Sir Arthur Hurst. He retired from the staff of Grey's Hospital having reached the age of sixty in 1939. Up to the time of his death, five years later, he remained actively occupied with teaching, writing, and consulting work. Latterly, he had devoted his leisure hours, with no small enjoyment for himself but great profit to you and me, to the writing of his personal reminiscences. **A Twentieth Century Physician,** being the reminiscences of Sir Arthur Hurst, D. M., F. R. C. P. ($3.50. *Williams & Wilkins, Baltimore, Md.).* Trained in the Oxford School of Physiology, Dr. Hurst was among the first to foster the regular application of physiological principles and methods to the study of problems at the bedside. All of this led to "team work." Professor John A. Ryle, his physician and friend, with the help of Lady Hurst, has arranged the manuscripts into chapters and so we have a peep into the soul of a great human being and a great physician.

PAUL B. BARRINGER

During the "great snow" of February, 1857, a baby boy was born in Harris Hotel in the town of Concord in North Carolina. It seems that the home of the Barringers was being enlarged and its roof raised; the contractor had been slow in his work, "then as now." So the parents were caught with this event at the local hotel. There were no hospitals thereabouts in those days and people of means would not have dared to go to them if there had been. In **The Natural Bent** ($3.50. *University of North Carolina, Chapel Hill, N. C.),* Anna Barringer has collected and arranged her father's memoirs. Because of his contact with so many things in the last half of the Nineteenth Century, a study of his active life gives us an insight into the times—one of the most extraordinary phases of history, The War between the States; the plantation; camp followers; the pinch of necessity in reconstruction days. Also covered are his school days as a student at Kenmore University and at the University of Virginia (1875); the School of Medicine (1876); the clinics of New York (1877-78); the grand tour of Europe (1881); and student of medicine in Vienna.

Dr. Barringer's personal recollections ended with his return to America. His professional career began with his return to North Carolina in 1882. He made his first appearance before the State Medical Society that same year with a paper on syphilis. This was a disease which his studies in Paris led him to believe was much neglected in the South.

In the fall of 1890, he became professor of

physiology and surgery at the University of Virginia. The book goes on to tell of his part in building up the Medical College until he accepted the presidency of V. P. I. in 1907. Death came on January 9, 1941. This book is a fitting tribute to a great teacher, and is a source of delight for anyone interested in the development of our country from 1857 to 1941.

JAMES B. HERRICK

These autobiographies of men who have lived full lives are a source of much historical information for those who can judge human nature. They are almost always good reading regardless of their value as historical documents. The beloved James B. Herrick of Rush Medical College has told the story of his own boyhood, medical school days, experiences in hospital work and private practice, his teachings and writings.

Anyone who is trying to understand the past eighty years of medical practice and education in the Midwest cannot afford to miss this wealth of information written by a meticulous scholar who tries very hard to be factual. **Memories of Eighty Years,** by James B. Herrick ($5.00. *University of Chicago Press, Chicago, Ill.).*

Whereas Paul Barringer's memoirs stop when his days of preparation for living and practicing in a small town were over, James Herrick takes on through a full and busy life in a large city to the end. Everyone who faces the problem of old age should read his eight-page chapter on old age.

"Keine Kunst ist alt zu werden
Es ist Kunst es zu ertragen."

To go along with the story of the two American physicians who studied in Europe and became great teachers of American Medicine: Dr. Barringer in the small town of Charlottesville, Virginia, Dr. Herrick in Chicago, we have the biography and philosophy of a European physician in **Janos,** The Story of a Doctor, by John Plesch ($5.00. *A. A. Wyn, Inc., New York City).* He gives us 260 pages of science, politics and personalities in the center of Europe. In Part Two, he tells us of the theatre, arts and music, and his escape to England. Finally, there is the appendix with its essays on "doctor's dialogues," as they are called—110 pages of comments on life.

IRMA GROSS DROOZ, M. D.

The titles of the chapters of the autobiography of a modern physician must be monotonously alike. The birth of our hero, his impression of his relatives, his school days, medical school and its teachers, hospital and postgraduate experiences and through his days of specialization and practice. The story of Dr. Drooz as told in **Doctor of Medicine** ($3.00. *Dodd, Mead & Co., New York City),* is no exception. The young lady who is the subject of this biography begins her story with the depression of the '30's. And so we have a book of inspiration for those who find obstacles in their way to the study of medicine. She was admitted to New York University, however, with the class of 1937. We follow the young woman medical student with lively and enlightening comments on all of the courses and the research in which she came to have a part during her hospital days and the war and back to New York with the final chapter on preventive psychiatry and how she started her practice thirteen years after she entered medical school. All this makes a good book for young people in the biological science courses who might decide to study medicine.

SIDNEY V. HAAS

On April 5, 1949, more than a hundred physicians and laymen paid tribute to Dr. Sidney V. Haas, the internationally known pediatrician, at a luncheon at the New York Academy of Medicine. The committee in charge prepared a small volume commemorating the event and in honor of Dr. Haas' contribution to celiac therapy and the treatment of the hypertonic infant, and the completion of his fiftieth year of medical practice.

MEDICAL MISSIONARIES

One of the most interesting stories in medicine is the work of medical missionaries. **In Doctors Courageous** ($3.50. *Harper & Bros., New York City),* Edward H. Hume, M. D., has told this with detachment and a wide perspective even though he is the son of a missionary to India and he, himself, has been a missionary to China. The work in Africa, India, Pakistan, the Near and Middle East and China is covered in this study for the Christian Medical Council for Overseas Work.

Famous Men of Medicine ($2.50. *Dodd, Mead & Company, New York City),* by Caroline A. Chandler, M. D., author of **Susie Stuart, M. D., Home Front Doctor,** etc., is one of the series of biographies of famous people for young people. The text extends from Hippocrates to Hans Zinsser and the new frontiers.

More students of medical history should be encouraged by local societies to write local medical histories. Dr. Webster Merritt last year published **A Century of Medicine in Jacksonville and Duval County** ($3.50. *University of Florida, Gainesville, Florida).* Working under the guidance of the late T. Frederick Daus, an outstanding historian of Jacksonville, Dr. Merritt began the task of assembling the material and constructing the record. As the years go by, fires destroy records, eye witnesses die, and the task of reconstructing the medical history of the times becomes increasingly difficult. Our county medical societies could do a job of "public relations" by promoting similar projects.

Proceedings of The Council . . .

Special Committees for Year Are Appointed by Incoming President; Other Matters of Importance Are Transacted at Cleveland Session

A REGULAR meeting of The Council of the Ohio State Medical Association was held on Monday evening, May 15, 1950, in the Rose Room, Hotel Cleveland, Cleveland, Ohio, on the eve of the 1950 Annual Meeting of the Association. This meeting followed a social hour and dinner attended by members of The Council, a number of past-presidents and committee chairmen, officials of the Cleveland Academy of Medicine and members of the Columbus office staff.

On **motion** duly made, seconded and unanimously **carried**, the minutes of the meetings of The Council held on April 22 and 23, 1950, were **approved.**

Membership statistics were announced as follows: Total membership as of May 12, 1950, 7,321; compared to a total membership of 7,479 as of December 31, 1949.

DISABILITY INSURANCE

The Council considered a resolution and statement of policy on compulsory temporary disability compensation and on **motion** duly made, seconded and unanimously **carried**, authorized the introduction of the resolution and statement of policy to the House of Delegates, scheduled to meet on Tuesday morning, May 16. (See Minutes of Meetings of House of Delegates elsewhere in this issue.)

A communication dated May 1 from the Superintendent of Salem City Hospital was read and discussed. On **motion** duly made, seconded and unanimously **carried**, the Executive Secretary was instructed to write the superintendent of that hospital as follows:

> "The basic principle expressed in the statement of policy on the practice of medicine by hospitals, adopted by The Council on April 23, 1950, applies to your communication of May 1, namely:
>
> "It is illegal for a hospital, regardless of its size or location, to contract for medical services.
>
> "Interns and residents are agents of the medical staff of the hospital. The medical staff is responsible for their acts and should outline their duties. Ethical principles which apply to members of the medical staff apply equally to interns and residents."

CIVILIAN DEFENSE

Dr. C. C. Sherburne, Columbus, chairman of the Committee on National Emergency Medical Service, and Dr. Edgar P. McNamee, Cleveland, who represented the Ohio State Medical Association at the training course in Cleveland on the medical aspects of atomic warfare, discussed the question of civilian defense. Dr. Sherburne reported on a conference which he had attended recently at the A. M. A. Headquarters in Chicago.

Following their discussions, on **motion** duly made, seconded and unanimously **carried**, The Council adopted a resolution requesting each county medical society to set up a committee on emergency medical service to work with the state committee, which in turn is cooperating with the Governor and other state officials on the matter of planning and establishing an Ohio civilian defense program.

V. A. CONTRACT RENEWED

Renewal of a contract with the Veterans Administration, as amended, relating to the care of disabled veterans by physicians in private practice, who are members of the Ohio State Medical Association, was authorized on **motion**, duly made, seconded and unanimously **carried.**

A communication from the International Rescue and First Aid Association, asking the Association to supply speakers for a meeting planned in Columbus, Ohio, was discussed. It was the general opinion of members of The Council that the first aid and rescue field is now being adequately covered by the American Red Cross and the National Safety Council in cooperation with various medical organizations and that duplication of effort on the part of duplicating organizations in this field is inadvisable. On **motion** duly made, seconded and **carried**, The Council did not authorize the Association to provide speakers for the meeting referred to.

MATTER LEFT TO DELEGATES

A communication from the Medical Society of New Jersey, asking this Association to approve a resolution to be presented by New Jersey delegates to the House of Delegates to the A. M. A. in San Francisco, in which was incorporated a twelve-point program covering health and medical services, was discussed. On **motion** duly made, seconded and **carried**, The Council did not approve the program submitted by New Jersey, but instructed the Executive Secretary to refer the matter to Ohio's delegates for consideration, leaving it to them to use their own discretion on the question when

it is brought before the House of Delegates of the A. M. A.

A vote of appreciation and thanks to Dr. Lincke, the retiring president, was given by The Council, on motion duly made, seconded and unanimously carried.

The Council expressed regret at the inability of Dr. J. Craig Bowman, Upper Sandusky, Councilor of the Third District, and Dr. Harry V. Paryzek, Cleveland, Chairman of the Cleveland Committee on Arrangements, to attend this session due to illness and authorized the sending of flowers to them.

There being no further business, The Council recessed to meet with the House of Delegates on Tuesday morning, May 16.

SESSION HELD ON MAY 18

A regular meeting of The Council of the Ohio State Medical Association was held on Thursday afternoon, May 18, 1950, in the Ballroom of Hotel Cleveland, Cleveland, Ohio, following the second session of the House of Delegates, with Dr. E. O. Swartz, the incoming president, presiding.

The principal business transacted was confirmation of special committee appointments made by Dr. Swartz, as follows:

Auditing and Appropriations—Dr. Carll S. Mundy, Toledo, chairman; Dr. R. J. Foster, New Philadelphia; Dr. H. M. Clodfelter, Columbus.

Committee on Cancer—Dr. C. E. Hufford, Toledo, chairman; Dr. John H. Lazzari, Cleveland; Dr. Carl A. Wilzbach, Cincinnati; Dr. L. A. Pomeroy, Cleveland; Dr. Robert M. Zollinger, Columbus; Dr. Robert T. Allison, Jr., Akron; Dr. E. P. McNamee, Cleveland; Dr. W. D. Nusbaum, Lancaster; Dr. Walter A. Reese, Middletown.

Committee on Chronic Illness—Dr. Harry V. Paryzek, Cleveland, chairman; Dr. Frank A. Riebel, Columbus; Dr. Joseph I. Goodman, Cleveland Heights; Dr. W. B. Lacock, Columbus; Dr. Cecil Striker, Cincinnati; Dr. Herman J. Nimitz, Cincinnati; Dr. Jonathan Forman, Columbus; Dr. John L. Stifel, Toledo, Dr. Floyd W. Craig, Coshocton, Dr. Nelson D. Morris, Toledo; Dr. H. W. Brettell, Steubenville.

Committee on Industrial Health and Workmen's Compensation—Dr. H. P. Worstell, Columbus, chairman; Dr. Robert A. Kehoe, Cincinnati; Dr. Louis N. Jentgen, Columbus; Dr. John M. Van Dyke, Canton; Dr. James N. Wychgel, Cleveland; Dr. Warren A. Baird, Toledo; Dr. A. L. Bershon, Toledo; Dr. Donald E. Yochem, Columbus; Dr. Rex H. Wilson, Akron; Dr. Wm. Ashe, Gallipolis; Dr. Joseph Lindner, Cincinnati.

Subcommittee on Legislation—Dr. G. A. Woodhouse, Pleasant Hill, chairman; Dr. Frank Mayfield, Cincinnati; Dr. Floyd M. Elliott, Ada; Dr. D. J. Slosser, Defiance; Dr. Wm. Garver, Cleveland; Dr. Wm. S. Skipp, Youngstown; Dr. Jay W. Calhoon, Uhrichsville; Dr. Clyde M. Fitch, Portsmouth; Dr. James B. Johnson, Jr., Newark; Dr. Donald F. Bowers, Columbus; Dr. George F. Linn, Norwalk.

Committee on Medical Service Plans—Dr. Robert C. Rothenberg, Cincinnati, chairman; Dr. Wm. M. Skipp, Youngstown; Dr. Jonathan Forman, Columbus; Dr. R. K. Finley, Dayton; Dr. Robert E. S. Young, Columbus; Dr. Carll S. Mundy, Toledo; Dr. Robert T. Allison, Jr., Akron; Dr. Azel Ames, Jr., Hamilton; Dr. R. J. Whitacre, East Cleveland; Dr. Edmond K. Yantes, Wilmington; Dr. Carl A. Lincke, Carrollton.

Committee on Mental Hygiene—Dr. Dwight M. Palmer, Columbus, chairman; Dr. Neil T. McDermott, Cleveland; Dr. Louis J. Karnosh, Cleveland; Dr. Maurice Levine, Cincinnati; Dr. Howard Fabing, Cincinnati; Dr. R. E. Pinkerton, Akron; Dr. O. M. Lawton, Youngstown; Dr. J. L. Sagebiel, Dayton.

Committee on National Emergency Medical Service—Dr. C. C. Sherburne, Columbus, chairman; Dr. Robert Conard, Wilmington; Dr. Cyrus R. Wood, Port Clinton; Dr. Carl R. Damron, Mansfield; Dr. Robert M. Zollinger, Columbus; Dr. Harry R. Huston, Dayton; Dr. W. O. Ramey, Cincinnati; Dr. E. A. Ockuly, Toledo; Dr. Claude S. Perry, Columbus; Dr. Drew L. Davies, Columbus; Dr. Robert E. Tschantz, Canton; Dr. Maurice M. Kane, Greenville; Dr. Fred Berlin, Lima; Dr. William J. Graf, Cincinnati; Dr. Herbert B. Wright, Cleveland; Dr. Morris G. Carmody, Painesville; Dr. George Sackett, Cleveland.

Committee on Rural Health—Dr. J. Martin Byers, Greenfield, chairman; Dr. Carll S. Mundy, Toledo; Dr. Jonathan Forman, Columbus; Dr. W. B. Recker, Leipsic; Dr. E. G. Caskey, Mineral Ridge; Dr. James M. Snider, Marysville; Dr. H. T. Pease, Wadsworth; Dr. A. D. Harvey, Lebanon; Dr. L. E. Anderson, Greentown; Dr. H. R. Mayberry, Bryan; Dr. E. K. Yantes, Wilmington; Dr. F. M. Hartsook, Cardington; Dr. Carl F. Goll, Hopedale; Dr. Kenneth Taylor, Pickerington.

Committee on School Health—Dr. Thomas E. Shaffer, Columbus, chairman; Dr. Carl A. Wilzbach, Cincinnati; Dr. J. W. Wilce, Columbus; Dr. Charles T. Atkinson, Middletown; Dr. L. A. Hamilton, Athens; Dr. T. L. Light, Dayton; Dr. R. E. Shell, Van Wert; Dr. John F. Miller, Newark; Dr. Margaret O'Neal, Zanesville; Dr. F. A. Halloran, Springfield; Dr. H. B. Thomas, Gallipolis; Dr. Russell C. Bane, Chillicothe; Dr. J. M. Painter, Kent; Dr. Charles F. Good, Cleveland.

Committee on Medical Care of Veterans—Dr. Drew L. Davies, Columbus, chairman; Dr. Robert Conard, Wilmington; Dr. Harry R. Huston,

Dayton; Dr. Wm. W. Trostel, Piqua; Dr. W. W. Green, Toledo; Dr. Edgar Northrup, Marietta; Dr. John H. Marshall, Findlay; Dr. Ivan C. Smith, Youngstown; Dr. Lewis W. Cellio, Columbus; Dr. Charles L. Shafer, Mansfield; Dr. L. D. Allard, Portsmouth; Dr. Robert L. Eastman, Mt. Vernon; Dr. E. H. Crawfis, Cleveland; Dr. T. H. Vinke, Cincinnati.

Woman's Auxiliary Advisory Committee—Dr. H. M. Clodfelter, Columbus, chairman; Dr. M. D. Prugh, Dayton; Dr. John S. Hattery, Mansfield.

Prior to adjournment Dr. Swartz announced that the Fall meeting of The Council will be held at the Granville Inn, Granville, Ohio, on Friday evening, September 15, and Saturday and Sunday, September 16 and 17.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

Allergy May Be Tipoff on Man Wanted by the F. B. I.

The Federal Bureau of Investigation has requested the medical profession to help in locating one Frederick J. Tenuto, who has been known also by several aliases. A complaint was filed before the U. S. Commissioner at Philadelphia, Pa., on February 17, 1950, charging this subject with violating Title 18, U. S. Code, Section 1073, in that he fled from the state of Pennsylvania to avoid confinement after conviction for the crime of murder.

Tenuto is described as follows: Age 35; height 5′ 5″; weight 143 pounds; build, stocky; hair, black; eyes, dark brown; complexion, dark; race, white; nationality, American; education, six years; occupation, butcher's helper, sheet metal worker, laborer; scars and marks, imperfect tatoo "S. J." on left forearm, imperfect tatoo on right forearm which may be "ANA," "ANNA" or "AMA," small brown mole on right cheek, 1½ inch scar over right eye. Has suffered from a recurring skin eruption. This man is considered extremely dangerous.

Medical records indicate that Tenuto has an allergy background and is allergic to some types of hairs and fibers. It was necessary at one time to furnish him with a cotton mattress. He has suffered from a type of eczema, which condition may recur at any time without apparent cause. At one time due to this condition, his eyes were swollen almost shut. Medical records disclose the following treatment: "Intramuscular injections of whole blood, 5 cc. every other day, and, externally, phenol, 15 gr., menthol, 2 gr., glycerine, 1 dram, liquor-carbonis-detergen, ½ oz. and aqua qs., 4 oz."

Anyone having information about this man is requested to communicate with the nearest F. B. I. office.

Cincinnati Sanitarium Announces Expansion of Visiting Staff

The Cincinnati Sanitarium has announced an expansion of its services to patients through the establishment of an enlarged visiting staff of leading Cincinnati psychiatrists.

The visiting staff has been organized with Dr. Louis Lurie as chairman, Dr. J. Robert Hawkins, vice-chairman, and Dr. John Campbell, secretary. Others on the visiting staff include Dr. William Roach, Dr. Max Lurie, Dr. Robert Buckley, Dr. R. Charles Smith, Dr. Rolland Leslie, Dr. Howard Fabing, Dr. William T. Gordon and Dr. Harry Salzer.



LOUIS LURIE, M. D.

Elliott E. Otte, business administrator of the Sanitarium, said the newly-organized group was formed to develop close cooperation between the hospital resident staff, headed by Dr. Douglas A. Johnston, medical director, and visiting psychiatrists. Dr. Wilford N. Wright is resident psychiatrist, and Dr. Henry Gruener is resident physician.

The Cincinnati Sanitarium, founded in 1873, is one of the oldest private hospitals in the United States for the care and treatment of nervous and mental patients. It is located on 29 acres of landscaped grounds.

Among the more recent changes are the new kitchens, completed early this year, which are equipped with advanced improvements for the storage of food and the preparation of meals.

The buildings include a rest cottage for the care of certain psychoneuroses and rest and convalescent cases. This is operated as a separate department of the hospital.

The Cincinnati Sanitarium is a member of the American Hospital Association, Ohio Hospital Association, and Central Neuropsychiatric Hospital Association, and is approved by the American College of Surgeons and by the Council of Hospitals, and is licensed by the State of Ohio.

American College of Physicians Offers Research Fellowships

The American College of Physicians announced that a limited number of Fellowships in Medicine will be available from July 1, 1951, to June 30, 1952. The stipend will be from $2,200 to $3,200. Further information may be obtained by addressing the College at 4200 Pine St., Philadelphia 4, Pa. Applications must be submitted not later than Oct. 1, 1950.

House of Delegates . . .

Official Proceedings of Sessions Held During 1950 Annual Meeting; New Officers, Councilor, Delegates and Committeemen Are Named

MINUTES OF FIRST SESSION

THE first session of the House of Delegates, held in conjunction with the 1950 Annual Meeting of the Ohio State Medical Association, convened in the Main Ballroom of Hotel Cleveland, Cleveland, Ohio, on Tuesday morning, May 16, 1950.

The meeting was called to order by Dr. Herbert B. Wright, President of the Cleveland Academy of Medicine, who welcomed the delegates to Cleveland and introduced the President, Dr. Carl A. Lincke, Carrollton. Dr. Lincke then gave his presidential address. **(See page 688 this issue for text of address.)**

The roll of delegates was called by the Executive Secretary, 118 delegates or alternates and councilors answering the roll call.

On **motion** duly made, seconded and **carried**, the minutes of the sessions of the House of Delegates held at the 1949 Annual Meeting in Columbus **were approved.**

REFERENCE COMMITTEES APPOINTED

Dr. Lincke appointed the following reference committees to consider business coming before the House of Delegates and for reports back to the House:

Resolutions—H. B. Wright, Cleveland, chairman; J. Martin Byers, Greenfield; G. A. Woodhouse, Pleasant Hill; R. E. Shell, Van Wert; O. E. Todd, Toledo; Wm. M. Skipp, Youngstown; J. S. Adler, Strasburg; George Malley, Zanesville; Newton Spears, Ironton; Gilman D. Kirk, Columbus; Leonard A. Stack, Lorain.

President's Address—R. K. Ramsayer, Canton, chairman; C. T. Atkinson, Middletown; E. H. Artman, Chillicothe; Carl F. Goll, Hopedale; D. J. Slosser, Defiance.

Time and Place of Annual Meeting—Joseph Lindner, Cincinnati, chairman; Kurt Weidenthal, Hudson; T. L. Light, Dayton; N. P. Stauffer, Millersburg; W. B. Recker, Leipsic.

Credentials—D. C. Houser, Urbana, chairman; W. G. Lyle, Minerva; F. P. Berlin, Lima; Paul F. Orr, Perrysburg; John L. Frazer, Wellston.

Tellers and Judges of Election—M. G. Carmody, Painesville, chairman; E. K. Yantes, Wilmington; John S. Kiess, Bucyrus; Robert M. Dumm, Kent.

COMMITTEE ON NOMINATIONS

The next order of business was the nomination and election of the following to the Committee on Nominations:

First District—Joseph Lindner, Cincinnati, chairman.
Second District—J. E. Gillette, Versailles
Third District—Fred P. Berlin, Lima.
Fourth District—A. L. Bershon, Toledo.
Fifth District—David A. Chambers, Cleveland.
Sixth District—Wm. M. Skipp, Youngstown.
Seventh District—Carl F. Goll, Hopedale.
Eighth District—W. D. Monger, Lancaster.
Ninth District—H. D. Chamberlain, McArthur.
Tenth District—Thomas Curran, Columbus.
Eleventh District—Leonard Stack, Lorain.

RESOLUTIONS INTRODUCED

President Lincke then called for the introduction of resolutions. The following resolutions were introduced:

Resolution A was introduced by Dr. C. T. Atkinson, Middletown, Butler County, and related to A. M. A. Fellowship.

Resolution B was introduced by Dr. Leonard A. Stack, Lorain, Lorain County, and related to A. M. A. Fellowship.

Resolution C was introduced by Dr. A. L. Bershon, Toledo, Lucas County, and related to the shortage of interns.

Resolution D was introduced by Dr. Kurt Weidenthal, Hudson, Summit County, and related to the practice of medicine by hospitals.

Resolution E was introduced by Dr. C. S. Higley, Cleveland, Cuyahoga County, and related to the "Hess Report," pending before the House of Delegates of the American Medical Association.

Resolution F was introduced by Dr. Leonard A. Stack, Lorain, Lorain County, and related to the "Hess Report," pending before the House of Delegates of the A. M. A.

Resolution G was introduced by Dr. James Mithoefer, Cincinnati, Hamilton County, and related to the participation by physicians in the "get out the vote campaign" in Ohio.

Resolution H was introduced by Dr. S. J. Shapiro, Warren, Trumbull County, and related to the waiver of dues for physicians in practice 50 or more years.

Resolution I, submitted on behalf of The Council, related to compulsory temporary disability compensation.

All of these were referred without debate to the Reference Committee on Resolutions. **(See minutes of Second Session of House of Delegates**

for texts of resolutions and action taken by the House of Delegates.)

Under miscellaneous business the House of Delegates authorized the reissuance of a charter to the Fairfield County Medical Society, that society having mislaid its original charter.

There being no further business, the House of Delegates recessed to meet on Thursday noon, May 18.

MINUTES OF SECOND SESSION

The second session of the House of Delegates was called to order by President Lincke at 1:30 p. m., Thursday, May 18, 1950, in the Main Ballroom, Hotel Cleveland.

The roll call showed 118 delegates or alternates and members of The Council in attendance.

Before calling for reports of the Reference Committees, President Lincke introduced Mr. E. H. O'Connor, Managing Director, Insurance Economics Society of America, Chicago, who addressed the House of Delegates on the question of compulsory temporary disability compensation.

At the request of President Lincke, Dr. H. B. Wright, Cleveland, chairman of the Reference Committee on Resolutions, submitted the following report:

"Mr. President, the Reference Committee on Resolutions herewith submits the following report on the nine resolutions presented to the House of Delegates at its session held on Tuesday, May 16:

RESOLUTION I

(See page 686 in this issue for report on this resolution, opposing compulsory temporary disability compensation, which was approved by the House of Delegates, on motion duly made, seconded and carried.)

RESOLUTION A AND RESOLUTION B

"Resolution A, presented by Dr. C. T. Atkinson, Middletown, on behalf of the Butler County Medical Society, and Resolution B, presented by Dr. Leonard A. Stack, Lorain, on behalf of the Lorain County Medical Society, were considered jointly by the Reference Committee. These resolutions deal with the same subject; namely, fellowship in the American Medical Association. The committee is in favor of the sentiments expressed in these resolutions and herewith submits a composite susbtitute resolution, reading as follows, and recommends its adoption by this House of Delegates:

"**Whereas,** There is constantly growing confusion, misunderstanding and criticism among the members of the American Medical Association regarding 'Fellowship,' and

"**Whereas,** A classification of members known as 'Fellows' is, in the opinion of many members, unnecessary, and

"**Whereas,** The relationship between the American Medical Association and its members would be improved by establishing a single membership classification in order that all members would receive uniform benefits in return for their annual membership dues, therefore,

"**Be It Resolved,** That the House of Delegates of the Ohio State Medical Association in session May 16, 17 and 18, 1950, favors a single membership classification in the American Medical Association; requests the Board of Trustees of the American Medical Association to prepare appropriate amendments to the Constitution and By-Laws and to submit the same to the House of Delegates for action; and recommends that serious consideration be given to formulating a feasible plan whereby each member would receive *The Journal of the A. M. A.*, or any special scientific journal published by the Association, as part of his all-inclusive membership benefits, and further

"**Be It Resolved,** That Ohio's delegates to the American Medical Association are herewith instructed to present this resolution to the House of Delegates of the American Medical Association at the 1950 annual session in San Francisco.

"Mr. President, I move the adoption of this portion of the report."

On **motion** duly made, seconded and **carried,** the recommendation of the committee, namely, that the above composite substitute resolution be adopted, was approved.

RESOLUTION E AND RESOLUTION F

"Resolution E, presented by Dr. C. S. Higley, Cleveland, on behalf of the Cleveland Academy of Medicine, and Resolution F, presented by Dr. Leonard A. Stack, Lorain, on behalf of the Lorain County Medical Society, are identical resolutions dealing with the "Hess Report" regarding the practice of medicine by hospitals.

"This resolution reads as follows:

"**Whereas,** Chapter III, Article VI, Section 6, of the recently adopted revised Principles of Ethics of the American Medical Association reads:

PURVEYAL OF MEDICAL SERVICE

"Section 6—A Physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

"**Whereas,** The committee known as the Hess committee reported to the American Medical Association House of Delegates in Atlantic City in June 1949, in detail, regarding the Practice of Medicine by Hospitals.

"**Whereas,** The Hess report in one paragraph stated in explanation as follows: "Therefore, hospitals and medical schools cannot charge patients fees for medical services rendered by physicians even though the physicians are full time employees of an individual or institution.

"**Whereas,** The Hess report was adopted by the American Medical Association House of Delegates and the Trustees of the American

Medical Association were instructed to enforce the principles and obligations involved.

"**Whereas,** The House of Delegates of the American Medical Association in Washington in December, 1949, reaffirmed its belief in and confirmed the principles stated in the Hess report and directed that action by the Trustees be deferred only until all legal requirements were met in order to insure that all actions taken shall comply with the law.

"**Whereas,** The Trustees of the American Medical Association are to report to the House of Delegates in June, 1950, regarding this matter and the "Hess" committee is to report its further study.

"**Therefore, Be It Resolved,** The House of Delegates of the Ohio State Medical Association confirms the action of the American Medical Association House of Delegates regarding the reaffirmation of the Principles of the so-called "Hess" report.

"**Be It Further Resolved,** The House of Delegates of the Ohio State Medical Association requests the American Medical Association House of Delegates to expedite action and implement methods that WILL enforce the Section 6, Article VI, Chapter III of the Principles of Medical Ethics without delay.

"**Be It Further Resolved,** Our Delegates to the American Medical Association are hereby instructed regarding these desires and requested to work for their fulfillment.

"Your committee endorses these resolutions and recommends their adoption.

"Mr. President, I move the adoption of this portion of the report."

On **motion** duly made, seconded and **carried,** the recommendation of the committee, namely, that Resolution E and Resolution F be adopted, was approved.

RESOLUTION C

"Dr. A. L. Bershon, Toledo, presented Resolution C on behalf of the Toledo Academy of Medicine, reading as follows:

"American medicine is being charged by certain factions as offering insufficient medical care. The Profession recognizes that there is basis in part for some of these charges, due to a dearth of General Practitioners and a concentration of doctors in the urban centers. This deficiency of General Practitioners is directly associated with over-emphasis on specialization in the university centers resulting in a lack of interns in the Non-University Hospitals, the hospitals which are, and should continue to be, the best training centers for the General Practitioners of Medicine.

"**Whereas,** There are 807 approved hospitals[1] in the United States offering a total of 9,124 internships, and

"**Whereas,** These hospitals reported only 7,068 first and second year interns on active duty, leaving 2,056 vacancies on 1 September 1948, and

"**Whereas,** The University Hospitals comprising only 25 per cent of the approved hospitals, with only 29 per cent of the total beds[2] and only 23 per cent of the total patient admissions, have 47.4 per cent of the available internships with only 17 per cent vacancies—or 1 intern to each 21 1/3 beds—leaving the Non-University Hospitals with 70 per cent of the total vacancies —or 1 intern to every 60 beds, and

"**Whereas,** This critical shortage of interns is working a hardship on the Non-University affiliated hospitals which are taking care of 77 per cent of the patients in our country, making it more difficult for them to render adequate service, resulting in poor public relations for the profession, therefore.

"**Be It Resolved,** That the approved hospitals of the City of Toledo, through the Academy of Medicine of Toledo and Lucas County, hereby petition the Ohio State Medical Association to urge the American Medical Association to request that the teaching University Hospitals directly connected with their medical schools cease to offer first year rotating internships, thus making available approximately 1500 graduates each year to fill the large number of vacancies in the Non-University affiliated hospitals. The first year men thus released under this plan would receive an intimate association with the general practice of medicine in these Non-University affiliated hospitals and be stimulated to enter this field, thus helping to relieve the critical shortage of General Practitioners which is so acute today.

"This resolution refers to the lack of general practitioners by virtue of concentration of physicians in urban centers and to over-emphasis on specialization resulting in a shortage of interns in non-university hospitals. The resolution recommends that this Association should urge the American Medical Association to request the teaching university hospitals to cease offering first year rotating internships, thus making available a considerable number of medical school graduates each year for internships in non-university hospitals.

"In reviewing this resolution the committee felt that there are certain impracticable features in the recommendations. Also, it is a fact that the House of Delegates and the Council on Medical Education and Hospitals of the American Medical Association have been giving serious study to this question in an effort to find a workable solution. At the 1949 annual session of the American Medical Association House of Delegates the appointment of a special committee to study this question was authorized. The matter was again discussed at the December, 1949, session of the House of Delegates of the A. M. A. It is expected that the special committee which is trying to work out a plan for a better distribution of interns will report its findings and recommendations at the 1950 session of the House of Delegates in San Francisco this coming June.

"For these reasons your Reference Committee recommends that Resolution C should not be adopted by this House of Delegates.

"Mr. President, I move the adoption of this portion of the report."

The action of the Reference Committee was discussed by Dr. Carll S. Mundy, Toledo, Coun-

1. J. A. M. A., Vol. 140, No. 2. May 14, 1949, pp. 157, 158.
2. J. A. M. A., Vol. 140, No. 2, May 14, 1949, pp. 161 through 170.

cilor of the Fourth District, and by other members of the House of Delegates. Following the discussion, Dr. Mundy presented the following amendment to become a supplemental paragraph of the report of the Reference Committee on Resolution C:

"However, in view of the seriousness of this situation in many localities, the Ohio delegates to the A. M. A. are hereby instructed to keep in close touch with the A. M. A. Committee considering this question and to do everything in their power to expedite an early solution to the problem."

On **motion** duly made, seconded and **carried**, the amendment presented by Dr. Mundy was agreed to.

Subsequently, on **motion** duly made, seconded and **carried**, the report of the Reference Committee as amended, relating to Resolution C, was **approved.**

RESOLUTION G

"Resolution G, which was presented by Dr. James Mithoefer, Cincinnati, on behalf of the Cincinnati Academy of Medicine, urges members of the medical profession and members of their family to participate in the state-wide "get-out-the-vote campaign" and actively work for the election of experienced, able candidates. This resolution reads as follows:

"**Whereas,** The General Election next November 7 will be one of the most important in the history of this state, and

"**Whereas,** It is imperative that well-qualified persons be elected to public offices, especially to seats in the United States Congress and the Ohio General Assembly, and,

"**Whereas,** It is the duty and responsibility of each physician, as a good citizen, to qualify for the privilege of voting and to cast his vote on Election Day, therefore

"**Be It Resolved,** That this House of Delegates urges each member of the Ohio State Medical Association and voting members of his family to register with their county board of elections, if required and if they have not done so; and to vote on Election Day, and

"**Be It Resolved,** That all members and members of their family give their active support to the state-wide "get out the vote campaign" and that they actively work for the election of experienced, able candidates.

"Your Reference Committee heartily endorses this resolution and expresses the hope that each County Medical Society in Ohio, through its legislative committee and otherwise, will take an active part in efforts being made to get all citizens to register and vote and to elect well-qualified candidates for public offices, especially to seats in the United States Congress and the Ohio General Assembly. Your committee, therefore recommends the adoption of this resolution.

"Mr. President, I move the adoption of this portion of the report."

On **motion** duly made, seconded and **carried**, the recommendation of the committee, namely, that Resolution G be adopted, was **approved.**

RESOLUTION D

"Resolution D, presented by Dr. Kurt Weidenthal, Hudson, on behalf of the Summit County Medical Society, reads as follows:

"**Whereas,** The Blue Cross Plan, Akron Hospital Service, has desired to include payment for anesthesia, provided the anesthetist is in the employ of the hospital, and

"**Whereas,** Said inclusion is a further attempt to furnish medical services by hospitals, and

"**Whereas,** Said inclusion is in direct opposition to the wishes of the anesthesiologists as well as other members of the Summit County Medical Society, and

"**Whereas,** The Hess Report As Revised is directly opposed to the furnishing of medical services by hospitals for financial gain, and

"**Whereas,** Such inclusion in hospitalization plans is another wedge in the furtherance of socialized medicine, therefore

"**Be It Resolved,** That the Blue Cross Plans organized in the State of Ohio be informed by the Ohio State Medical Association that such practice is contrary to the wishes of physicians in general, and to anesthesiologists in particular, and such hospitalization plans should not provide coverage which encroaches upon the private practice of medicine, and

"**Be It Further Resolved,** That the Ohio State Medical Association shall oppose all hospitalization plans that provide medical services furnished by hospitals beyond those in common practice at this time, and

"**Be It Further Resolved,** That the Hess Report As Revised be accepted by the Ohio State Medical Association, and

"**Be It Further Resolved,** That all medical indemnity insurance plans, particularly Ohio Medical Indemnity, The Doctors Plan, be urged to include anesthesia as a medical service to counteract the trend toward including it as a hospital service, and

"**Be It Further Resolved,** That a copy of this resolution be transmitted to the proper committees of the Ohio State Medical Association and the American Medical Association for their guidance in the desires of this House of Delegates relative to the encroachment of hospitals upon the private practice of medicine.

"This resolution was reviewed very carefully by your committee.

"One portion of the resolution refers to the Hess Report. This subject has already been disposed of through action on Resolutions E and F.

"Another section of the resolution urges medical indemnity insurance plans, particularly Ohio Medical Indemnity, to include coverage for anesthesia services as a part of their contracts. Your committee has been advised that Ohio Medical Indemnity has already taken the appropriate steps to carry out this recommendation.

"The balance of the resolution express opposition to the inclusion of medical services in hospitalization insurance plans. The Ohio State Medical Association already has a definite policy on this matter. On October 8, 1939, The Council

of the Ohio State Medical Association adopted the following principles as a guide in evaluating hospital insurance contracts:

" 'The subscriber's contract should exclude all medical services. Contract facilities should be limited exclusively to hospital facilities such as bed, board, operating room, medicines, surgical dressings, general nursing care, and services of intern and resident staff in assisting the subscriber's attending physician.'

"Therefore, your committee recommends that Resolution D not be adopted, and further recommends that this House of Delegates reaffirm the principles adopted by The Council on October 8, 1939, as the official policy of the Ohio State Medical Association. Moreover, it recommends that County Medical Societies use these principles as the basis for conferences and discussions with representatives of hospital insurance plans.

"Mr. President, I move the adoption of this portion of the report."

On **motion** duly made, seconded and **carried,** the recommendation of the committee, namely, that Resolution D not be adopted, was **approved.**

RESOLUTION H

"Resolution H was presented by Dr. S. J. Shapiro, Warren, on behalf of the Trumbull County Medical Society. This resolution recommends that the Ohio State Medical Association exempt from the payment of annual dues, those physicians who have been honored for their fifty years in medical practice.

"The Reference Committee favors the intent of this resolution and herewith submits a substitute resolution and recommends its adoption.

SUBSTITUTE RESOLUTION H

"**Resolved,** That the Constitution and By-Laws of the Ohio State Medical Association be amended to exempt from the payment of annual dues of the Ohio State Medical Association those members who have been graduates of a medical school for at least 50 years and that The Council be instructed to prepare proper amendments to the Constitution and By-Laws of the Ohio State Medical Association for submission to the House of Delegates for action at the 1951 annual session of the Ohio State Medical Association.

"The Reference Committee would like to point out to the House of Delegates that the Constitution and By-Laws of the Ohio State Medical Association provide that proposed amendments to the Constitution and By-Laws must be published in *The Ohio State Medical Journal* at least 30 days prior to the session of the House of Delegates at which such proposed amendments are to be acted upon.

"Mr. President, I move the adoption of this portion of the report."

President Lincke called for discussion of the substitute resolution presented by the Reference Committee and the motion to adopt the substitute resolution.

Dr. D. C. Houser, Urbana, senior member of the House of Delegates, a member of the House of Delegates since 1902 and a past-president of the Association, took the floor and presented vigorous objections to this resolution. Dr. Houser stated that he had always considered it an honor and a privilege to be an active dues-paying member of the Ohio State Medical Association and he said he felt that the overwhelming majority of the older members of the Association felt the same way. Dr. Houser said that he believes it would not be proper to place the older members in an "old age pension" classification. Dr. Houser recommended that the substitute resolution and the motion to adopt the substitute resolution should be disapproved.

The motion to adopt the substitute resolution as seconded was put to a vote and the motion was defeated by an overwhelming vote.

REPORT, AS AMENDED, APPROVED

Dr. Wright then moved that the report of the Reference Committee, as amended, be approved. The motion was seconded and carried.

Dr. Wright then expressed appreciation to the following members of his committee for the fine work which they had done and for having devoted so much time to the resolutions considered: Dr. J. Martin Byers, Greenfield; Dr. G. A. Woodhouse, Pleasant Hill; Dr. R. E. Shell, Van Wert; Dr. O. E. Todd, Toledo; Dr. Wm. M. Skipp, Youngstown; Dr. J. S. Adler, Strasburg; Dr. George Malley, Zanesville; Dr. Newton Spears, Ironton; Dr. Gilman D. Kirk, Columbus; Dr. Leonard A. Stack, Lorain.

REPORT ON PRESIDENT'S ADDRESS

Dr. R. K. Ramsayer, Canton, chairman of the Reference Committee on the President's Address, submitted the following report which had been endorsed and signed by the following committee members, including the chairman: Dr. C. T. Atkinson, Middletown; Dr. E. H. Artman, Chillicothe; Dr. Carl F. Goll, Hopedale; Dr. D. J. Slosser, Defiance.

"The Committee on President's Address, composed of Drs. Artman, Atkinson, Goll, Slosser and Ramsayer, after due study and deliberation, wishes to submit the following report:

"Doctor Lincke presented a well organized and complete discussion of the activities, achievements and objectives of the Ohio State Medical Association, during his tenure of office, in a concise, positive and interesting manner. For the purposes of clarity and analysis, his speech may be divided into three principal parts.

"The first portion pertains to the activities and high spots of progress of the past fifty years. He emphasizes that medical science has produced its greatest achievements during this period, and exceeds all those since the dawn of history.

"Doctor Lincke points out that the progress made in the field of sanitation and public health

education has advanced from no organization to a now highly efficient specialty, exerting complete control of public health education and the collection of vital statistics. Likewise, therapeutics and pharmacology, with its latest developments of antibiotics, serums and other drugs, which were unheard of at the beginning of the Century. Surgery has advanced from the kitchen-table techniques, with poor or no anesthesia, to the highly skillful methods used in the everyday procedures in our modern hospitals. Likewise, the modern hospital of today was unheard of fifty years ago.

SCIENTIFIC DEVELOPMENTS

"During this period, the development of electricity, the automobile and the dissemination of news and information by telephone, telegraph, press, radio and television, has completely changed the environment and daily practice of the physician. The public has become interested in health matters, and not so many years ago, little or no public attention was paid to health welfare. The Rockefeller Foundation was about the only organization other than the medical societies taking an interest in advancing the art of science and medicine.

"Today, millions of people are taking a keen interest in these subjects in various manifold organizations in the field of medical care.

"Likewise, during this interim, many programs of insurance protection have developed, as witnessed by our Workmen's Compensation system, voluntary participation in hospital and medical care insurance plans and disability coverage and the like.

"While these things have been taking place, our own organization has grown and expanded to meet the demands and needs of our times. The central office of the Ohio State Medical Association has grown from one executive secretary and one stenographer in dingy quarters to its present fine downtown Columbus offices, with twelve full-time employees and a number of part-time assistants. The acknowledgment by Dr. Lincke that the Ohio State Medical Association functions as an efficient organization in the category of big business behind its officers, speaks well for an able leadership during the past year.

OHIO MEDICAL INDEMNITY

"He emphasizes that one of its departments, the Ohio Medical Indemnity prepayment medical care plan, is the fifth largest of its kind in the United States, and provides coverage against the costs of many illnesses and disabilities for more than 700,000 Ohioans. The President particularly pays tribute to the employees of our Columbus office for their faithful service and interest, and mentions especially our executive secretary, Chuck Nelson, and his assistant, Scottie Saville, for their untiring efforts and loyal devotion to duty.

"The second portion of the President's Address pertains to the activities of the Ohio State Medical Association through its officers and various committees. During the year just concluded under the leadership of Dr. Lincke, our organization has maintained and continued, by the highest standards, its dedicated principle of preserving, protecting and promoting the practice of medicine and public health in the American Way. The challenge of the profession, 'Do right by the people,' in our personal and professional relationship, is not going unheeded. Categorically, our President has reviewed and emphasized the high spots of our many committees and organizations. Time will allow for re-emphasis of only a few.

"Our President reaffirms that each county medical society represents one of the most important organizations in the community and as such, either as a society or via its individual members, has definite obligations to fulfill, as well as many opportunities of promoting goodwill among the public. These obligations and responsibilities in the community can only be reposed in a virile and aggressive leadership in our several county societies, and upon their achievements depend the destiny of our state organization. This will help to eliminate a large portion of public grievances and quiet those who would have government medicine. The individual physician continues to be the master of our destiny.

THE DOCTOR AS A CITIZEN

"Doctor Lincke emphasizes with top priority the great need for physicians assuming their responsibilities as citizens. In these times of social changes, it was never more important that the physicians, as an intelligent and educated component of our civilization, should make their views known, not only in politics, but in closer liaison with their representatives in state and national congresses. Never in the history of our organization has it been so necessary as in this election year of 1950, that we vote and work to cause others to vote, proving ourselves to be good citizens as well as good doctors.

"Your committee feels that Dr. Lincke, in his refreshed emphasis on the activities and expansion of the public relations and educational committees during his tenure of office, has been at a loss of expression to note the real facts, chiefly due to modesty on his part. He should have said that probably more has been accomplished during the past year through his own efforts and, through the State Association, the county medical societies and the individual physicians, than in any previous year.

RURAL HEALTH

"Also, in studying his address we are reminded that a former president of some 18 years ago in his annual address said, 'The health of the people is one of the prime objectives of government and unless the medical profession devises some plan or plans whereby the public can obtain the best medical and surgical care, the government may be compelled to provide such a plan.' The year-by-year review of some of the milestones in public relations since 18 years ago, and especially since the adoption of the 25-point program of 1945, finds that our profession has been devising plans for better and better medical and surgical care and these plans are rapidly and aggressively being carried forward towards ultimate completion. One illustration is the activity of the Association's Committee on Rural Health, which has already excited national attention. Medical scholarships and the doctor placement service are and will contribute greatly to the solution of the rural problems.

"Furthermore, the address stresses the far-reaching effects of the public relations and education committees, in disseminating important facts and information via the speakers' bureau, the press, the *OSMAgram*, the radio and television to all the communities in Ohio, again developing a strong bulwark against government medicine. Also, the rapidly growing and ex-

panding Ohio Medical Indemnity, Inc., is a concrete example of financial benefits to the citizens of Ohio and a powerful asset in times of sickness.

"In conclusion, our Committee, in complete unanimity, agrees that Dr. Lincke has given a very comprehensive review of the medical past, with its tremendous accomplishments, and has challenged the profession for a greater and more glorious future. We hope our sons will pick up the gauntlet and ride forward, to further accomplishments without the aid of government subsidies. Dr. Lincke, in his own modest way, has proven himself a dynamic leader and has achieved much in many difficult circumstances. He has acquitted himself well, and is deserving of the Society's "heartfelt thanks" for his year of unselfish service to our Association."

On **motion** duly made, seconded and **carried,** the report of the Reference Committee on President's Address was **approved.**

TIME AND PLACE OF MEETINGS

The next order of business was the report of the Reference Committee on Time and Place of Annual Meeting.

Dr. Joseph Lindner, Cincinnati, chairman of that committee, submitted the following report:

"Mr. President and members of the House of Delegates, the Committee on Time and Place of Annual Meeting deems it advisable to recommend a change in the place for the 1952 Annual Meeting. Columbus has been chosen as the place for the 1952 Annual Meeting, but experiences from last year's Annual Meeting show that present facilities in Columbus are not adequate.

"Therefore, your committee recommends that the 1952 Annual Meeting be held in Cleveland during the month of May, if possible, the exact time to be designated by The Council.

"Also this House of Delegates should act with respect to the 1953 Annual Meeting. Your committee recommends that the 1953 Annual Meeting be held in Columbus, providing the new civic auditorium being planned for Columbus is ready and available by the month of May, 1953. The question of setting the exact date of the meeting should be left to The Council. (Note: The 1951 Annual Meeting will be held in Cincinnati, April 24, 25 and 26.)

"Mr. President, I move the adoption of the recommendations of the Reference Committee on Time and Place of Annual Meeting."

The **motion** was duly seconded and unanimously **carried.**

The report of the committee was signed by Dr. Joseph Lindner, Cincinnati, chairman; Dr. Kurt Weidenthal, Hudson; Dr. T. L. Light, Dayton; Dr. N. P. Stauffer, Millersburg; and Dr. W. B. Recker, Leipsic.

ELECTION OF PRESIDENT-ELECT

President Lincke then called for nominations for the office of president-elect, the Constitution and By-Laws requiring that such nominations must be made from the floor.

Dr. C. C. Sherburne, Columbus, a delegate from Franklin County and a past-president of the Association, placed in nomination the name of Dr. Fred W. Dixon, Cleveland, retiring Councilor of the Fifth District. Dr. Wright, President of the Cleveland Academy of Medicine, and a delegate from Cuyahoga County, seconded the nomination.

There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for the election of Dr. Dixon to the office of president-elect. This was done and Dr. Dixon was elected to the office of president-elect.

At the request of President Lincke, Dr. Sherburne escorted Dr. Dixon to the rostrum where he was introduced and given an ovation by the House of Delegates. Dr. Dixon then made a brief talk pledging his support of the policies and programs of the Association.

ELECTION OF COUNCILORS

The President then called for the report of the Committee on Nominations. Dr. Joseph Lindner, Cincinnati, chairman of that committee, submitted the following report:

First District

As Councilor for the First District, the committee placed in nomination the name of Dr. D. **W. Heusinkveld, Cincinnati,** to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Heusinkveld. This was done and Dr. Heusinkveld was declared officially elected to The Council for the years 1950 and 1951.

Third District

As Councilor for the Third District, the committee placed in nomination the name of **Dr. J. Craig Bowman, Upper Sandusky,** to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Bowman. This was done and Dr. Bowman was declared officially elected to The Council for the years 1950 and 1951.

Fifth District

As Councilor for the Ffth District, **Dr. Charles L. Hudson, Cleveland,** was nominated to succeed Dr. Fred W. Dixon, Cleveland, who retired automatically from The Council due to the fact that he had served three consecutive terms

and who had been elected president-elect. There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Hudson. This was done and Dr. Hudson was declared officially elected to The Council for the years 1950 and 1951.

Seventh District

As Councilor for the Seventh District, the committee placed in nomination the name of **Dr. R. J. Foster, New Philadelphia,** to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Foster. This was done and Dr. Foster was declared officially elected to The Council for the years 1950 and 1951.

Ninth District

As Councilor for the Ninth District, the committee placed in nomination the name of **Dr. J. P. McAfee, Portsmouth,** to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. McAfee. This was done and Dr. McAfee was declared officially elected to The Council for the years 1950 and 1951.

Eleventh District

As Councilor for the Eleventh District, the committee placed in nomination the name of **Dr. John S. Hattery, Mansfield,** to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Hattery. This was done and Dr. Hattery was declared officially elected to The Council for the years 1950 and 1951.

A. M. A. DELEGATES ELECTED

The committee then presented nominations for the offices of delegate and alternate to the American Medical Association to be filled at this year's meeting, such delegates and alternates to take office January 1, 1951, and to serve for a term of two years, namely, 1951 and 1952.

The names of **Dr. Edgar P. McNamee, Cleveland,** and **Dr. Herbert B. Wright, Cleveland,** as delegate and alternate, respectively, to serve for a term of two years, starting January 1, 1951, were placed in nomination. There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. McNamee and Dr. Wright. This was done and they were declared duly elected delegate and alternate to the American Medical Association for two years, starting January 1, 1951.

The names of **Dr. Carl A. Lincke, Carrollton,** and **Dr. Herbert M. Platter, Columbus,** as delegate and alternate, respectively, to serve for a term of two years, starting January 1, 1951, were placed in nomination. There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Lincke and Dr. Platter. This was done and they were declared duly elected delegate and alternate to the American Medical Association for two years, starting January 1, 1951.

The names of **Dr. George A. Woodhouse, Pleasant Hill,** and **Dr. Roy S. Binkley, Dayton,** as delegate and alternate, respectively, to serve for a term of two years, starting January 1, 1951, were placed in nomination. There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Woodhouse and Dr. Binkley. This was done and they were declared duly elected delegate and alternate to the American Medical Association for two years, starting January 1, 1951.

The names of **Dr. Wm. M. Skipp, Youngstown,** and **Dr. C. E. Hufford, Toledo,** as delegate and alternate, respectively, to serve for a term of two years, starting January 1, 1951, were placed in nomination. There being no further nominations, on **motion** duly made, seconded and **carried,** the nominations were closed and the Executive Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Skipp and Dr. Hufford. This was done and they were declared duly elected delegate and alternate to the American Medical Association for two years, starting January 1, 1951.

The Nominating Committee pointed out to the House of Delegates that the delegates and alternates just elected are incumbent delegates and alternates to the A. M. A. and that they would serve as such for the balance of 1950, starting their new terms officially January 1, 1951.

DR. SWARTZ INSTALLED

President Lincke then installed Dr. E. O. Swartz as President of the Association, presenting him with the official gavel of the Association. Following a brief talk, Dr. Swartz submitted the following appointments to the standing committees of the Association:

Committee on Public Relations and Economics —Dr. John A. Fraser, East Liverpool, for a term of five years. Dr. Herbert B. Wright,

Cleveland, a member of the committee, to serve as chairman for the ensuing year.

Committee on Education—Dr. J. L. Webb, Nelsonville, for a term of five years. Dr. Charles S. Higley, Cleveland, to serve as a member of the committee for the years 1950, 1951 and 1952, inclusive, filling the unexpired term of Dr. Edwin P. Jordan, Cleveland, resigned. Dr. Carl A. Wilzbach, Cincinnati, a member of the committee, to serve as chairman for the ensuing year.

Judicial and Professional Relations Committee—Dr. Neil Millikin, Hamilton, for a term of five years. Dr. John A. Caldwell, Cincinnati, a member of the committee, to serve as chairman for the ensuing year.

Committee on Scientific Work—Dr. Robert M. Zollinger, Columbus, for a term of five years. Dr. Martin W. Diethelm, Toledo, a member of the committee, to serve as chairman for the ensuing year.

On **motion** duly made, seconded and **carried**, the foregoing committee appointments were confirmed by the House of Delegates.

VOTE OF THANKS

Under the order of new business Dr. Wm. M. Skipp, Youngstown, moved that a vote of thanks be extended to the Cleveland Academy of Medicine, members of the Cleveland committees on arrangements, Hotel Cleveland, the management of the Public Auditorium, the press and radio, the Committee on Scientific Work, the Committee on Scientific Exhibits, and all others who had played a part in making the 1950 Annual Meeting the largest and one of the best in the history of the Association. This motion was adopted by a unanimous vote.

There being no further business, the House of Delegates adjourned sine die.

Attest: CHARLES S. NELSON,
Executive Secretary.

Health Services for Civilians With Military Forces Unified

Responsibility for the health program for civilian employees of the military forces has been assigned by Secretary of Defense Louis Johnson to the Surgeons General of the Army, Navy and Air Force, with each directing the program in his respective department under the over-all administrative, technical and professional control of Ohio's Dr. Richard L. Meiling, director of Medical Services, Office of the Secretary of Defense.

The order, effective July 1, 1950, replaces the former programs in which responsibility was scattered among several agencies of the Department of Defense, including the Surgeons General. Applicable to all Department of Defense installations, the order consolidates and unifies this health service.

A. M. A. Directory Now Being Distributed

After three years of work, the 18th edition of the A. M. A. directory has been completed and copies are now being shipped to subscribers.

The edition, the first since 1942, was compiled under extreme difficulties, and Editor Frank V. Cargill says that "it was only with the cooperation of the medical profession and allied organizations that it was possible to produce a directory of this scope."

The long interval of eight years between the new directory and the previous one made it necessary to set new type on the entire book. The loss of experienced clerical help during the war, labor conditions and printing difficulties also contributed to the delay.

The new directory contains 2,913 pages, and lists information on 219,677 physicians in the United States, its dependencies, and Canada. It also lists American graduates and licentiates located temporarily abroad. Since the 1942 directory, thousands of changes of address have been made; 51,984 names have been added, and 28,242 names dropped from the book on account of death or for other reasons.

In the 1942 directory, the total number of physicians listed in the United States was 180,496; in the 1950 edition, the number is 201,277, or a gain of 20,781, an average yearly gain of 2,598 during the last eight years.

The Pacific States show the largest increase in physicians, the Atlantic and Great Lakes States a moderate increase and the West Central States the greatest losses. California leads in the number gained, with 16,668 physicians in 1950 as compared with 12,365 in 1942, a gain of 4,303. New York state shows a gain of 2,284, Texas a gain of 772, Pennsylvania 704, Florida 634 and Massachusetts 603.

For the first time, postal zone numbers appear after the residence and office addresses of physicians in cities where they are required by the Post Office Department. A new feature is the inclusion of data on the World Medical Association.

The directory costs $25. Orders may be placed by writing to Frank V. Cargill, Directory Department, American Medical Association, 525 North Dearborn St., Chicago 10.

For every person who now dies of pneumonia or influenza, five would have died if the mortality rate of only 20 years ago had continued, Metropolitan Life Insurance Company reports.

The Southwestern Chapter of the Ohio Academy of General Practice had as speakers Dr. Othilda Krug and Dr. Eli A. Miller, both of Cincinnati, who spoke respectively on "Marriage Counseling" and "Controlled Fertility."

HOUSE OF DELEGATES
ROLL CALL—1950 MEETING

County	Delegate	First Session	Second Session
	FIRST DISTRICT		
ADAMS	S. J. Ellison	Present	Present
BROWN	W. L. Faul	----------	----------
BUTLER	Neil Millikin	----------	----------
	C. T. Atkinson	Present	Present
CLERMONT	A. A. Gruber	----------	Present
CLINTON	E. K. Yantes	Present	Present
HAMILTON	Joseph Lindner	Present	Present
	E. C. Elsey	Present	Present
	John W. Hauser	----------	Present
	Daniel V. Jones	Present	Present
	William F. Hunting	Present	Present
	Kent E. Martin	Present	Present
	James Mithoefer	Present	Present
	J. Edwin Reed	Present	Present
	Robert S. Green	----------	Present
HIGHLAND	J. Martin Byers	Present	Present
WARREN	O. L. Layman	----------	Present
	SECOND DISTRICT		
CHAMPAIGN	D. C. Houser	Present	Present
CLARK	S. C. Yinger	Present	----------
	R. M. Turner	Present	Present
	E. W. Schilke	----------	Present
DARKE	J. E. Gillette	Present	----------
GREENE	H. C. Messenger	Present	Present
MIAMI	G. A. Woodhouse	Present	Present
MONTGOMERY	R. S. Binkley	Present	Present
	A. W. Carley	Present	Present
	R. D. Dooley	Present	Present
	T. L. Light	Present	Present
PREBLE	E. P. Trittschuh	----------	----------
SHELBY	H. E. Crimm	Present	----------
	THIRD DISTRICT		
ALLEN	F. P. Berlin	Present	Present
AUGLAIZE	C. W. Berry	----------	Present
CRAWFORD	John S. Kiess	Present	----------
HANCOCK	Frank M. Wiseley	Present	Present
HARDIN	Floyd M. Elliott	Present	----------
LOGAN	Warren F. Mills	Present	Present
MARION	Robert T. Gray	----------	Present
MERCER	L. M. Otis	----------	----------
SENECA	R. F. Machamer	Present	----------
VAN WERT	R. E. Shell	Present	Present
WYANDOT			
	FOURTH DISTRICT		
DEFIANCE	D. J. Slosser	Present	Present
FULTON	E. M. Murbach	----------	----------
HENRY	B. L. Johnson	----------	Present
LUCAS	A. L. Bershon	Present	Present
	O. E. Todd	Present	Present
	E. E. Lyon	Present	Present
	R. Kuebbeler	Present	Present
	R. A. Diethelm	Present	Present
OTTAWA	C. R. Wood	Present	Present
PAULDING	R. H. Mouser	----------	----------
PUTNAM	W. B. Recker	Present	Present
SANDUSKY	J. Gedert	Present	Present
WILLIAMS	H. R. Mayberry	Present	Present
WOOD	Paul F. Orr	Present	Present
	FIFTH DISTRICT		
ASHTABULA	M. R. Martin	Present	----------
	P. J. Collander	----------	Present
CUYAHOGA	H. B. Wright	Present	Present
	D. A. Chambers	Present	Present
	J. H. Budd	Present	Present
	D. C. Darrah	Present	Present
	C. L. Hudson	Present	Present
	J. T. Ledman	Present	Present
	J. E. Brown	Present	Present
	George A. Tischler	Present	Present
	F. L. Browning	Present	Present
	L. H. Dembo	Present	Present
	C. S. Higley	Present	Present
	E. A. Marshall	Present	Present
	H. A. Crawford	Present	Present
	J. M. Rossen	Present	Present
	I. M. Hinnant	Present	----------
	J. W. Conwell	Present	Present
GEAUGA	Phillip P. Pease	Present	Present
LAKE	Morris G. Carmody	Present	Present
	SIXTH DISTRICT		
COLUMBIANA	J. A. Fraser	Present	Present
MAHONING	V. L. Goodwin	Present	Present
	C. A. Gustafson	----------	Present
	Wm. M. Skipp	Present	Present
PORTAGE	Robert M. Dumm	Present	Present
STARK	John E. Dougherty	Present	Present
	C. C. Couch	Present	Present
	R. K. Ramsayer	Present	Present
SUMMIT	Kurt Weidenthal	Present	Present
	W. T. Bucher	Present	Present
	C. A. Raymond	Present	Present
	E. W. Burgner	Present	Present
TRUMBULL	S. J. Shapiro	Present	Present
	SEVENTH DISTRICT		
BELMONT	Harvey H. Murphy	----------	Present
	David Danenberg	Present	----------
CARROLL	W. G. Lyle	Present	Present
COSHOCTON	E. J. Booth	----------	----------
HARRISON	Carl F. Goll	Present	Present
JEFFERSON	John Gallagher	----------	----------
MONROE	A. R. Burkhart	----------	----------
TUSCARAWAS	J. S. Adler	Present	Present
	EIGHTH DISTRICT		
ATHENS	Beatrice Postle	----------	Present
	M. H. Mitchell	Present	----------
FAIRFIELD	W. D. Monger	Present	----------
GUERNSEY	Robert A. Ringer	Present	Present
LICKING	George A. Gressle	Present	Present
MORGAN	Henry Bachman	----------	----------
MUSKINGUM	George C. Malley	Present	Present
NOBLE	Edward G. Ditch	----------	----------
PERRY			
WASHINGTON	Donald S. Williams	----------	----------
	NINTH DISTRICT		
GALLIA	Charles E. Holzer, Jr.	----------	----------
HOCKING	M. H. Cherrington	Present	----------
JACKSON	John L. Frazer	----------	----------
LAWRENCE	Newton Spears	Present	Present
MEIGS	Roger P. Daniels	----------	Present
PIKE	R. M. Andre	Present	Present
SCIOTO	O. D. Tatje	----------	Present
	L. R. Chaboudy	Present	----------
VINTON	H. D. Chamberlain	Present	Present
	TENTH DISTRICT		
DELAWARE	George J. Parker	----------	----------
FAYETTE	J. E. Rose	----------	Present
FRANKLIN	George F. Collins	Present	Present
	Phillip T. Knies	Present	Present
	Reuben B. Hoover	----------	Present
	Gilman D. Kirk	Present	Present
	Robert E. S. Young	Present	----------
	Thomas Curran	Present	----------
	C. C. Sherburne	Present	Present
KNOX	Henry T. Lapp	Present	Present
MADISON	Wm. T. Bacon	----------	----------
MORROW	J. P. Ingmire	Present	Present
PICKAWAY	E. L. Montgomery	----------	----------
ROSS	E. H. Artman	Present	Present
UNION	F. C. Calloway	Present	Present
	ELEVENTH DISTRICT		
ASHLAND	R. J. Ferguson	Present	Present
ERIE	Ross M. Knoble	Present	Present
HOLMES	N. P. Stauffer	Present	Present
HURON	Owen J. Nicholson	Present	Present
LORAIN	Leonard A. Stack	Present	Present
	Russell Arnold	Present	Present
MEDINA	Wm. E. Dwyer	Present	Present
RICHLAND	P. A. Blackstone	Present	Present
WAYNE	Lyman A. Adair	Present	----------
	OFFICERS		
President	Carl A. Lincke	Present	Present
President-Elect	E. O. Swartz	Present	Present
Past-President	A. A. Brindley	Present	Present
Treasurer	H. P. Worstell	Present	Present
	COUNCILORS		
District			
First	D. W. Heusinkveld	Present	Present
Second	Merrill D. Prugh	Present	Present
Third	J. Craig Bowman	----------	----------
Fourth	Carll S. Mundy	Present	Present
Fifth	Fred W. Dixon	Present	Present
Sixth	Paul A. Davis	Present	Present
Seventh	R. J. Foster	Present	Present
Eighth	Chester P. Swett	Present	Present
Ninth	J. P. McAfee	Present	Present
Tenth	H. M. Clodfelter	Present	Present
Eleventh	John S. Hattery	Present	Present
	Totals	118	118

Disability Compensation . . .

House of Delegates Resolution Opposes State Plan for Compulsory Non-Occupational Sickness Benefits; Favors Voluntary Protection

THE most important question of policy considered by the House of Delegates at the recent Annual Meeting of the Ohio State Medical Association was that pertaining to compulsory temporary disability compensation.

A resolution prepared by The Council opposing compulsory temporary disability insurance was presented to the House of Delegates.

The resolution was revised by the Reference Committee on Resolutions and reported back to the House, with a recommendation that it be adopted.

The House of Delegates approved without a dissenting vote, the report of the Reference Committee.

Following is the text of the Reference Committee's report, including the resolution and statement of policy on the question:

TEXT OF REPORT

"Resolution I was presented on behalf of The Council. This resolution recommends that the House of Delegates shall approve and adopt an official statement of policy regarding compulsory temporary disability compensation, which statement of policy is incorporated in the resolution.

"The intent of this resolution is to provide representatives of the Ohio State Medical Association with information and arguments which they can use before legislative bodies in opposing a compulsory state plan of non-occupational sickness and accident benefits. Your Reference Committee held two long sessions for the purpose of discussing this important proposal. **It recommends the adoption of the resolution and statement of policy with certain amendments.** The resolution and the amended statement read as follows:

"**Resolved,** That the House of Delegates of the Ohio State Medical Association, consisting of official representatives of Ohio's 88 County Medical Societies, in annual session in Cleveland, Ohio, May 16, 17 and 18, 1950, herewith approves and adopts the following statement as the official policy of the Ohio State Medical Association on compulsory temporary disability compensation.

"When the 99th Ohio General Assembly convenes in 1951, it may be requested to enact legislation, establishing in Ohio a compulsory state plan of non-occupational sickness and accident benefits.

"During the past year a special commission created by act of the last General Assembly has been holding hearings on this question, preparatory to compiling a report, with recommendations, to the next General Assembly.

"This question should be of vital concern, not only to members of the medical profession, but to all citizens of Ohio.

"Serious and far-reaching economic, social and political implications are involved.

"In addition, a state-controlled program to compensate a worker for loss of earnings for non-occupational injuries and illnesses—in other words, cash sickness compensation—would be accompanied by innumerable medical administrative problems, affecting the practice of medicine and patient-physician relationships.

VOLUNTARY SYSTEM FAVORED

"The medical profession of Ohio endorses the principle that every worker should voluntarily protect himself and members of his family against the hazards of non-occupational illness and injury.

"Moreover, the medical profession is in agreement with the principle that public assistance, including medical and hospital services, should be provided on a state or local basis for those in need, regardless of the cause.

"On the other hand, the medical profession of Ohio is opposed to any system of compulsory disability insurance. It believes that it is neither necessary nor advisable, and submits the following specific arguments in support of this opinion:

OPINION SUBSTANTIATED

"Available data indicate that a high percentage of workers are covered at present for the hazards previously referred to. Such coverage is provided through private insurance contracts where employers are paying all, or part of the cost; or under mutual benefit plans operated by groups of employees; or by employees or employers jointly. It is a fact also that many employers continue to pay their workers their salary when absent from work due to sickness. Coverage can be secured without difficulty by workers not already covered and at a cost within their means.

"Great progress is being made by private insurance carriers in efforts to meet the needs of the average working man for protection of this kind. Benefits have been broadened; more complete coverage is being offered; costs have been lowered. Records show that private insurance companies which are competing with

state cash disability funds in California and New Jersey are offering broader protection and providing better claims service for the same premium cost than the state-operated fund.

"It would be exceedingly difficult, if not impossible, to make coverage under a state-wide compulsory system flexible or elastic enough to meet the varying needs of individual workers. Likewise, such a system would probably be unable to gear itself to varying economic and social conditions.

DECRY FURTHER REGIMENTATION

"A compulsory program would require a high degree of governmental regulation and regimentation, rigid controls and considerable red-tape, bookkeeping, paper work, etc., affecting insured workers, employers, physicians, and others participating in the program.

"Administration of a compulsory program would necessitate great expansion of some existing state agency or the creation of a new agency. Many new employees would have to be added to the state payroll. This additional overhead obviously would add considerably to the state budget.

"Compulsory disability insurance would inject the government still further into the relationship between physician and patient. This situation is now acute because of the expansion of government-controlled medical and health activities. Additional impairment of the physician-patient relationship would constitute a real danger which must not be overlooked.

"Obviously, it would be impossible to eliminate politics and political pressures from the administration of a compulsory program. Any system which is subject to political manipulation, regulated by a paternalistic government, and which develops in the insured individual the feeling that he has an inherent right to demand such benefits, is wide open to abuse, malingering, dishonesty and collusion. A compulsory disability program cannot be an exception to this rule.

POLITICAL CONSIDERATION

"Under a state disability program, subject to political pressures, benefits would be continuously expanded and liberalized without regard for actuarial principles. This would mean that deficits would have to be met from the state treasury, necessitating additional general taxes or special taxes. The only alternative would be increases in the premiums levied on workers and employers. This would add to the problems and maladjustments which already exist in our present economy of high taxes, high prices and inflation.

"Any state which adopts a compulsory disability insurance program is setting up the pattern for transfer to the Federal Government. Concentration of power, control and regimentation in the hands of the Federal Government, which has taken over many activities which could be handled better and more economically on a state or local basis, has created a dangerous situation.

STEP TO FEDERAL CONTROL

"Those who believe that establishment of a compulsory disability plan on a state basis will prevent the formation of a Federal system are naive, to say the least. They do not realize how easy it would be for the Federal Government to take over after a relatively few key states have adopted such a plan. This is the plan of those in power in Washington who are exerting pressure day after day for complete Federalization of all social insurance, welfare and health plans, and other governmental activities.

"Conversion of any compulsory non-occupational disability compensation program into a full-fledged compulsory health or sickness insurance scheme is relatively easy—in fact inevitable. Compulsory health insurance plans now operating in other nations started with a compulsory disability compensation program. When it becomes necessary to apply controls or to expand benefits, the inevitable trend is to regulate the professions and to add service benefits—medical, hospital, nursing, and dental care of claimants. This adds up to an over-all compulsory medical care system. Witness what has happened in California, where hospitalization is now covered under the state disability law. Witness the pressure which has been exerted in Rhode Island and New Jersey for similar service benefits—even in New York where the disability law will not even become effective until July 1, 1950. Compulsory disability compensation is the back-door entrance to general compulsory health insurance under government regulation and control. We are opposed to that.

"The time has come to call a halt to the present trend which is encouraging the surrender of individual initiative, destroying ambition and responsibility, and threatening our national economy with bankruptcy."

American College of Physicians Announces 1951 Meeting

The American College of Physicians will conduct its 32nd Annual Session at St. Louis, Mo., April 9-13, inclusive, 1951. Dr. Ralph Kinsella of St. Louis is the general chairman and will be responsible for local arrangements and for the program of Clinics and Panel Discussions.

Dr. William S. Middleton, president of the College, Madison, Wis., will be in charge of the program of Morning Lectures and Afternoon General Sessions.

The 1952 Annual Session of the College will be held at Cleveland, Ohio, April 21-25, 1952.

A Half-Century of Progress . . .

President of Association Reviews Some High Lights of the Past 50 Years and Makes Pertinent Comments About the Future of Practice

By CARL A. LINCKE, M. D.

(Presented to the House of Delegates, May 16, 1950, at Cleveland, Ohio)

IT is indeed a privilege and a pleasure to be president of the Ohio State Medical Association, and especially at this time—the midway mark of the Twentieth Century. Since this is the mid-century meeting of the Association, I think it would be appropriate to review some of the high spots of the progress of the past 50 years and to make a few comments about the future.

The past half-century has produced the greatest advancement in the science of medicine since the dawn of history. Permit me to enumerate a few high lights for the record.

In the field of sanitation, the outhouse has been brought inside, pure water substituted for contaminated wells and springs in a large part of the nation, and refrigeration has become a household necessity.

Public health administration, a vital part of the practice of medicine, has advanced from practically no organization to an efficient specialty, dealing with epidemic and contagious disease control, health education, collection of vital statistics, et cetera.

Great advances have been made in pathological research and in laboratory techniques, giving us new information about the cause of diseases and providing us with exact diagnostic methods.

Progress in therapeutics and pharmacology has given us antibiotics, serums, chemicals and other drugs which were unheard of at the turn of the century and efficient ways of using them.

PROGRESS IN SURGERY

Surgery has progressed from the kitchen-table technique under chloroform, or possibly no anesthesia, to the skillful methods used by today's surgeon. This, also, is true in the other specialties.

Hospital care has kept pace, dispelling the fear of hospitalization which prevailed in the minds of so many persons 50 years ago.

Scientific inventions and advancements benefiting the entire world have done much for the doctor and his patients. Take electricity as an example. It has supplied us with an energy that has made possible new methods of diagnosis and treatment.

Another example is the automobile. It and good roads have taken the place of the horse and buggy and the mud, landmarks still quite fresh in the minds of many physicians still in practice.

Still another example is the progress made in dissemination of news and information—by the press, telephone, radio and television.

A marked change has occurred in the attitude of the public toward medical and health matters. Not so many years ago the public paid little, or no, attention to such matters. About the only organizations, other than medical societies, taking an interest in advancing the art and science of medicine, medical education and public health education were the large philanthropic agencies, such as the Rockefeller Foundation.

Today, millions of people are taking a keen interest in these subjects. This is shown by the presence of many different organizations in the field of medical care and health education, such as organizations which are interesting themselves in crippled children, poliomyelitis, cancer, heart disease, arthritis, tuberculosis, diabetes, epilepsy, venereal diseases, and many others.

Programs to provide insurance protection have grown and multiplied by leaps and bounds as witnessed by our Workmen's Compensation system, voluntary hospitalization and medical care insurance plans, accident and disability coverage, and the like.

ASSOCIATION HAS GROWN

While these things have been taking place, our own organization has grown and been expanded to meet the demands and needs of the times. It is a far cry from the loosely knit organization of county societies which existed at the turn of the century to our Ohio State Medical Association of today.

It has not been many years since the Association employed its first executive secretary and established a permanent full-time office—in 1915 to be exact. The first executive secretary had one stenographer to assist him. His office was in dingy quarters. The budget for his activities was a mere pittance compared to our present annual budget of $140,000. Now our office occupies half of the top floor of a downtown office building in Columbus. We employ 12 persons on

a full-time basis and several others on a part-time basis.

Speaking of employees, I wish to take this opportunity to thank all of the employees of our Columbus office for their faithful services and interest, and to mention especially our Executive Secretary, Chuck Nelson, and his assistant, Scotty Saville, for their interest and work beyond the call of duty.

Our organization is in the category of big business, gentlemen—the business of providing a service program to preserve, protect and promote medicine and public health in the American Way. Also, I should point out that we also are in the insurance business. We own and control Ohio Medical Indemnity, the fifth largest voluntary prepayment medical care plan in the United States, which is now providing coverage against the costs of many illnesses and disabilities for more than 700,000 Ohioans, and which is showing a steady growth each month.

Now, let us focus our attention on some of the important events of the past year. It has been a busy year. I am happy to report that many things have been accomplished.

Developing better public relations has been one of the major activities of our Association. We all know that the foundation of good public relations is conscientious service to our patients in our daily practice, plus vigorous promotion of activities and services to improve the health of the public as a whole.

Our efforts to get our members to realize the need for improvement of their relationship, professionally and personally, with their patients is beginning to bear fruit. Our challenge to the profession to "do right by the people" is not going unheeded. The activities of our committees, such as the Committee on Rural Health and the Committee on School Health, to cite two outstanding examples, have demonstrated to the public that we are sincere in our efforts to carry out our basic purposes.

WINNING FRIENDS

As a result, more and more people are becoming our allies in our battle to preserve the freedom of the medical profession and to maintain high medical and health standards.

Our long-range approach to the job of winning friends and acquainting them with what we believe to be sound views on health matters is beginning to pay dividends. The job has just started. We must improve and expand our efforts during the coming year.

The record shows that our Association, through its Public Relations Department, with the help of the county medical societies and many individual physicians, has done a tremendous job in a tangible way during the past 12 months in the field of public relations. Various media—the press, radio, platform and literature—have been used successfully to get our message to the people.

Our Public Relations Department has cooperated fully with the American Medical Association in its National Education Campaign.

During the past year more than three million pieces of literature have been distributed from our Columbus office to physicians for their office waiting rooms, drugstores, insurance agents, hundreds of lay organizations, groups, clubs, etc.

All of the university, college and high school libraries in Ohio, numbering nearly 2,000, have been supplied with a comprehensive package of material, describing the advantages of voluntary health insurance and the dangers of compulsory health insurance. The package also contains information on other subjects related to the economic and social aspects of the practice of medicine, as well as valuable health education data. Similar packets have been sent to hundreds of participants in discussion groups.

Local medical societies were assisted in securing scripts and platters for radio broadcasts. Our State Speakers' Bureau has furnished speakers for many state and district public meetings, supplementing the fine job by most of the county medical societies in supplying speakers for local gatherings.

After receiving material from our Association reviewing the issue, nearly 500 Ohio organizations, including veterans organizations, civic groups, business and professional organizations, women's clubs, et cetera, have adopted resolutions opposing the enactment of compulsory health insurance. These actions have been called to the attention of the Ohio members of the Congress.

We have sponsored exhibits at the State Fair and at the annual conventions of the Ohio Congress of Parents and Teachers, Ohio Welfare Conference, Ohio Society for Crippled Children, Ohio Society of Medical Technologists, and similar groups. Also, our exhibits have been used at a number of county fairs under the sponsorship of the County Medical Society of the Woman's Auxiliary.

COMMITTEES ACTIVE

We can be proud of the work of our state committees. They have worked hard and have done a splendid job during the past year.

One of the most active committees is the Committee on Rural Health. It established the Ohio Rural Medical Scholarship and I am happy to report that the first recipient, Mr. C. Craig Wright, is progressing well with his studies at Ohio State University College of Medicine. A second scholarship will be awarded this summer. This committee has promoted the formation of

local community health councils. It has cooperated with the Ohio Rural Health Council. In the near future it will present to the deans of the Ohio medical schools a plan for a series of lectures for junior and senior medical students on practice in small communities and in rural areas.

The major activity of the Committee on School Health during the past year was a state-wide conference of school health committees of the County Medical Societies with school administrators, teachers and health officials. It is preparing material for local school health committees to guide them in working with school officials on school health problems.

The Committee on Cancer has organized teams which have been made available for programs at county medical society meetings. This idea has been popular. In fact, it has gone over so well that the Committee on Education is considering the formation of teams to present programs at local medical meetings on other subjects. The Committee on Cancer also has served in an advisory capacity to the Ohio Department of Health and Ohio Branch of the American Cancer Society which are carrying on cancer control and educational programs in the state.

A Committee on Chronic Illness has been appointed to study this problem and to make recommendations which can be used as the basis for a sound program of medical and institutional care for these unfortunates.

Earlier in my remarks I referred to Ohio Medical Indemnity. Our prepayment medical care plan has made great progress during the past year. A year ago it had about 500,000 persons covered. Today its enrollment exceeds 700,000. Many of the indemnities in the schedule have been increased. New procedures have been added. A rider to cover medical cases in the hospital is now being offered in several areas. After experience has been gained, this kind of coverage will be offered in all communities in which Ohio Medical is operating. The possibility and feasibility of adding coverage for X-ray and anesthesia services are being studied. A number of community enrollments have been held with considerable success. More will be held during the coming year. Experiments in enrolling small groups and individuals have been conducted in one area. If the results are favorable, coverage will be offered to small groups and individuals in other parts of the state.

50-YEAR AWARDS

Last fall we started a program of presenting gold emblems and certificates to physicians who had been in practice for at least 50 years. This idea, initiated by Past-President Rutledge, has been accepted with great enthusiasm. Nearly 400 awards have been presented by members of The Council at County Medical Society meetings. These ceremonies have received widespread publicity and built up fine public relations in the various communities. There is no doubt but what this will become an annual fall activity.

Our annual conference for County Medical Society officers and committeemen was a big success and beneficial to all who attended, I am sure. During the past year we sponsored an important state-wide conference for officers and committeemen of the local woman's auxiliaries and the state auxiliary. At both conferences the discussions high lighted the jobs ahead, the importance of the coming elections, public relations, et cetera.

Our *Ohio State Medical Journal* has continued to improve. The *OSMAgram* is becoming more and more popular and useful. The Placement Service at our Columbus Office has supplied physicians for a large number of small communities.

I wish to thank the officers, Councilors and the members of all of our committees for their untiring efforts and for the parts which they have played in making the record of the Association during the past year one of marked progress.

What of the future? Here are a few things which we must keep in mind in order to keep our over-all program in high gear.

Our County Medical Societies must have top-notch leadership. The destiny of the State Association rests in the hands of the County Medical Societies. The local societies will not be able to fulfill their obligations and meet their responsibilities unless they have alert, aggressive leaders at the helm.

I am sure you will agree that our public relations program must be improved and expanded. We have come a long way but we still have a long road to travel. This is not a one-man nor a one-society job. Its success will depend on mobilization of the resources of the State Association, those of the 88 county medical societies, and the active interest and cooperation of all members.

POOR CITIZEN—POOR DOCTOR

Another objective of major importance—I might say immediate importance—is to get every member of the Association actively interested in political, civic and community affairs. In this year 1950 I cannot over-emphasize how important it is for each physician and all members of his family to actively participate in political affairs, especially in the activities leading up to the General Election next November 7. The physician who is a poor citizen is, in my opinion, a poor doctor.

Moreover, we will have to step up our legislative activities as the chips may be down during the next session of Congress and during the

next regular session of the Ohio General Assembly, starting next January. We must be prepared to take a firm stand on all medical and health bills—supporting those which are in line with sound principles and policies; opposing those which, in our belief, would be detrimental to public health and to medical standards.

High priority should be given to extending the fine work which has been done by the Committee on Rural Health and the Committee on School Health. Each County Medical Society should have similar local committees and should give them real support.

We should continue to give our active and financial support to the Ohio Committee on Public Health which is carrying on an important educational program to improve our state and local public health departments. Our local societies can do much, if they will, to create public interest in the matter of improving local health departments and providing them with adequate local funds for operation expenses.

EXPANDING SERVICE

As the problems increase, it will become increasingly necessary for the State Association to provide more help and assistance to the County Medical Societies on such matters as providing speakers for meetings, clinical programs and field personnel from our Columbus Office. If additional field services are to be supplied from Columbus, it will be necessary to employ additional personnel. This should be given serious consideration.

Needless to say, our entire membership should give its active support to Ohio Medical Indemnity. We should strive to boost its enrollment to at least one million by the end of another year. We should make every possible effort to expand our contract both as to scope of coverage and in the amounts of the benefits. This is our best answer to those who think a compulsory governmental program is the only solution.

Efforts should be made to expand our contacts with governmental agencies and voluntary organizations interested in medical and health questions. By doing so we will be able to render our members greater service. At the same time we will be in a position to take a leading part in determining the policies and activities of these agencies.

These are just a few of the goals which we should have in mind as we start another Association year. By working hard to turn our aims into achievements and by serving our patients to the best of our ability, we will be carrying on the basic purposes of our organization. In doing so we will win additional respect and prestige for our Association and our profession. This offers a real challenge. Let's meet it!

Survey of College Health Services

The Bureau of Medical Economic Research of the A. M. A. is conducting a survey of the university and college health services for the academic year 1949-1950 to bring up to date the 1936 study, "University and College Student Health Services."

The purpose of the present survey is to determine what health services are being rendered by the college directly or by community physicians and hospitals through the college health service offices, and how these services are being financed.

A 12-page schedule is being sent to 1,150 colleges and universities to obtain data for faculty members, nonacademic employes and students. Insurance contracts with Blue Cross and Blue Shield plans and insurance companies, which have been made by some universities and colleges in addition to, or instead of, other methods of financing health services, are being surveyed.

The health services available to the faculty and nonacademic employes as well as to almost three million college students is of great interest and importance to American medicine, the director of the Bureau stated.

New Chief of Tuberculosis Division In Ohio Is Named

Dr. Arnold B. Kurlander who has been stationed in Ohio for approximately three and a half years by the U. S. Public Health Service, has been transferred to the Division of Tuberculosis of the Public Health Service in Washington, D. C.

Dr. John D. Porterfield, director of the Ohio Department of Health, said that during Dr. Kurlander's stay in Ohio a completely new system of central registration for tuberculosis cases has been developed and a method of evaluating the status of the tuberculosis program in each health district evolved, which has been recognized as a new contribution to the entire field of tuberculosis control.

Replacing Dr. Kurlander as chief of the Division of Tuberculosis of the Ohio Department of Health is Dr. Ralph E. Dwork. Dr. Dwork received his medical degree after studying at the Universities of Edinburgh and Glasgow, Scotland, and later received the degree of Master of Public Health at Columbia University. For the last year he has been health officer in charge of the Tremont and Fordham-Riverdale districts of New York City.

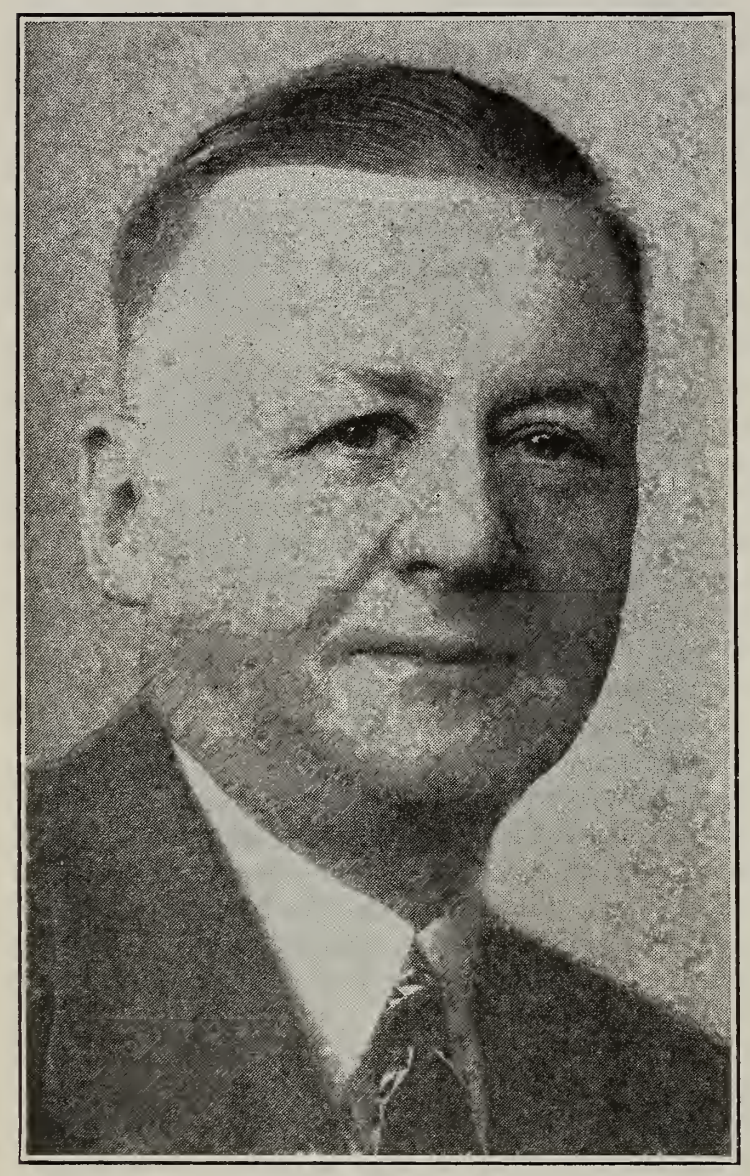
An estimated 19,000,000 of the adult population of the United States or about one out of five, changed residence during the year ending in April, 1949.

Presenting . . .

The New President-Elect and One New Councilor Elected at the Recent Annual Meeting In Cleveland; Comments on Other Officers

THE President-Elect and one new Councilor were elected as officers of the Ohio State Medical Association by the House of Delegates at the Annual Meeting in Cleveland. Following are biographical sketches of these new officers, a sketch of the incoming President, and a review of Councilors reelected.

Dr. Fred Willis Dixon of Cleveland is the President-Elect who will assume office as President at the 1951 Annual Meeting in Cincinnati. In that office he continues as a member of The Council on which he has served for the past six years. The Council consists of the President, the President-Elect, the immediate Past-President, the Treasurer and one Councilor for each of the 11 Districts. The Council is the interim governing body of the Association between meetings of the House of Delegates.



FRED W. DIXON, M. D.

Dr. Dixon was born on a farm near Mount Jackson, Pa., on November 18, 1888. After receiving his B. S. degree from Geneva College, Beaver Falls, Pa., in 1912, he attended the University of Pennsylvania School of Medicine from which he received the degree of Doctor of Medicine in 1917.

After completing an internship in City Hospital, Youngstown, he was commissioned in the Army Medical Corps and served in that capacity during World War I.

For approximately four years following the war, he engaged in general practice in Leetonia before he began a residency in the New York Eye and Ear Infirmary. In 1925 he completed his training in otolaryngology in Vienna. For the past 25 years Dr. Dixon has practiced in Cleveland.

Dr. Dixon is assistant professor, Department of Otolaryngology, Western Reserve University School of Medicine, and visiting otolaryngologist at Lakeside Hospital and St. Alexis Hospital. He is a Fellow of the American Medical Association, member of the American Academy of Otolaryngology, American College of Surgeons, the American Laryngological Society, the Rhinological and Otological Society, the American Broncho-Esophagological Association (in an editorial capacity), and a fellow of the American Laryngological Association. In addition, he is the author of numerous medical publications.

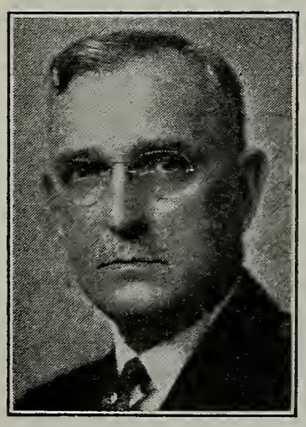
Dr. Dixon was elected Councilor of the Fifth District at the 1944 Annual Meeting to succeed Dr. Edgar P. McNamee of Cleveland. In 1946 and 1948 he was reelected

to succeed himself. Before being elected to that office, he served for five years as a member of the Committee on Scientific Work of the Association. He has since served on several committees, among which is the Committee on Auditing and Appropriations.

INCOMING PRESIDENT

Dr. E. O. Swartz, of Cincinnati, who was formally installed as President of the Ohio State Medical Association at the Annual Meeting in Cleveland, comes into office with many years of service in medical organization work.

He was born in Loudonville in Ashland County on February 6, 1880, and received his preparatory education at Portsmouth and in Warren County. For his premedical training, he attended Doane Academy and Denison University, Granville, where he received his first college degree. In 1905 he received the degree of Doctor of Medicine after completing the course at the Medical College of Ohio, now the University of Cincinnati College of Medicine.



E. O. SWARTZ, M. D.

Dr. Swartz was licensed the same year in Ohio, and in 1907 was licensed also by the Wisconsin State Board. After serving as an intern and later as a resident in medicine at the Cincinnati General Hospital, he engaged in general practice in Cincinnati until 1917.

In that year he began a year of graduate study in urology at Johns Hopkins Medical College and was assistant in urology at The Brady Urological Clinic, Johns Hopkins Hospital, from 1918 until 1921. During this time, under a grant from the U. S. Department of the Interior Hygiene Board, he collaborated in the production and its presentation to the medical profession of Mercurochrome.

From 1921 to the present time, Dr. Swartz has continued his practice in Cincinnati, limiting his work to genito-urinary surgery. He has contributed many articles to medical literature.

Dr. Swartz served as president of the Cincinnati Academy of Medicine for the term 1939-40. He served as Councilor for the First District from 1943 until 1949, and is serving as an alternate delegate to the American Medical Association. He has served on a number of committees of the Association, among which were the Committee on Public Relations and Economics, the Committee on Industrial Health, the Committee on Poor Relief, and the Auditing and Appropriations Committee of which he was chairman.

Dr. Swartz is assistant professor of surgery, Department of Urology, University of Cincinnati College of Medicine and is attending urologist at Cincinnati General Hospital, Children's Hospital, Christ Hospital and Deaconess Hospital, and is past-director and senior attending urologist at Jewish Hospital and Bethesda Hospital.

He was a member of the Coordinating Committee of the Cincinnati Public Health Federation. Other affiliations include membership in the American Urological Association, fellowship in the American College of Surgeons and recognition as a diplomate of the American Board of Urology.

Civic and fraternal activities include memberships in several Masonic orders including the Consistory and Shrine, Nu Sigma Nu, the Cincinnati Club, the University Club, the Travel Club, Pelee Club, the Cincinnati Automobile Club and the Baptist Church. Dr. and Mrs. Swartz have one son, Dr. William T. Swartz.

FIFTH DISTRICT COUNCILOR

Dr. Charles L. Hudson of Cleveland was elected by the House of Delegates as Councilor for the Fifth District, succeeding Dr. Fred W. Dixon, the new president-elect of the Association.

Dr. Hudson was born in Merrill, Michigan, on August 5, 1904. He completed his preparatory education at Saginaw High School and received his AB degree from Alma College. He was graduated as Doctor of Medicine from the University of Michigan in 1930.



C. L. HUDSON, M. D.

He was intern and assistant resident on the medical service of Lakeside Hospital, Cleveland, following which for two years he was a research fellow at the University of Pennsylvania under Dr. A. N. Richards doing research in kidney physiology. He was next chief medical resident at University Hospitals, Cleveland, and has been associated with University Hospitals and Western Reserve University since that time.

Dr. Hudson served as a Major in World War II with the 36th General Hospital in North Africa, Italy and France. He was separated from active service as a Lieutenant Colonel.

He is a member of Nu Sigma Nu, Phi Kappa Phi, Galens, Alpha Omega Alpha, American Federation for Clinical Research, American Medical Association, and is a diplomate of the American Board of Internal Medicine. He is

Associate Director of Western Reserve University Student Health Service, senior clinical instructor in Medicine at Western Reserve University and a member of the visiting staff of University Hospitals and Crile Veterans Administration Hospital. He practices internal medicine in Cleveland where he is a director of the Academy of Medicine.

Dr. and Mrs. Hudson have three children and live in Shaker Heights. His hobby is choral singing with the Hermit Club of Cleveland.

PAST-PRESIDENT

Dr. Carl A. Lincke, Carrollton, as immediate Past-President will continue to serve on The Council for another year, succeeding Dr. A. A. Brindley, Toledo, in that office.

COUNCILORS REELECTED

Councilors reelected for additional two-year terms are:

Dr. David W. Heusinkveld, Cincinnati, Councilor of the First District. Dr. Heusinkveld was elected to that office in 1949 to fill the one-year unexpired term of Dr. Swartz.

Dr. J. Craig Bowman, Upper Sandusky, Councilor of the Third District. Dr. Bowman was elected Councilor in 1946 and reelected in 1948.



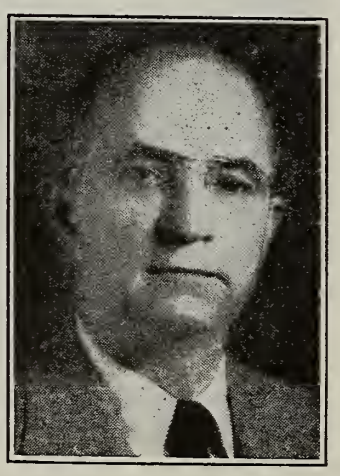
J. C. BOWMAN, M. D.



D. W. HEUSINKVELD, M. D.



J. P. McAFEE, M. D.



R. J. FOSTER, M. D.

Dr. R. J. Foster, New Philadelphia, Councilor of the Seventh District. Dr. Foster was elected to that office in 1948.

Dr. J. P. McAfee, Portsmouth, Councilor of the Ninth District. Dr. McAfee was elected to that office in 1948.

Dr. John S. Hattery, Mansfield, Councilor of the Eleventh District. Dr. Hattery was elected to that office in 1948.



J. S. HATTERY, M. D.

MID-TERM OFFICERS

Councilors in the midst of two-year terms are: Dr. Merrill D. Prugh, Dayton, Second District; Dr. Carll S. Mundy, Toledo, Fourth District; Dr. Paul A. Davis, Akron, Sixth District; Dr. Chester P. Swett, Lancaster, Eighth District; and Dr. H. M. Clodfelter, Columbus, Tenth District.

Dr. H. P. Worstell, Columbus, was reelected in 1949 for an additional three-year term as treasurer.

Legion Commander Adds Warning On Left Turns to Communism

National Commander George N. Craig of the American Legion said in an address in Chicago recently that "compulsory health insurance—political medicine—is bad medicine for America."

"If some of the crackpot do-gooders should have their way," he said, "they eventually would communize America. They tell us in honeyed words that more concentrated government control of everything will do something for us. They don't tell us what it would do to us."

The Legion chief spoke at the Silver Anniversary banquet of the Chicago Accident and Health Association. A group from the American Medical Association attended. Seated at the A. M. A. table were: President Ernest E. Irons, Tom Hendricks, Dr. Ernest B. Howard, Howard Brower, Dr. J. J. Moore, John L. Bach, and Walter McLaughlin and W. F. Mitchell of Whitaker & Baxter.

Commander Craig said that on two different occasions the American Legion had gone on record as opposed to a compulsory sickness insurance program.

"That," he said, "should leave no doubt that you and we stand on common ground—fighting a common enemy—socialism, the advance guard of communism.

"On the great American highway we have approached an intersection, at which is a bold warning sign—No Left Turn.

"And too many of our people are mentally indulging in the old wisecrack that they don't believe in signs."

Annual Meeting Review . . .

Streamlined Scientific Program, Large Number of Exhibits, Banquet, Other Features, Combine To Make Cleveland Session Most Successful

FOLLOWING the trend of postwar meetings toward increasing attendance, the 1950 Annual Meeting of the Association in Cleveland set another all-time record. The previous record attendance of 2,608 persons established last year in Columbus was exceeded by 424.

The number of persons who registered was 3,032. A breakdown of the registration is given on page 701 of this issue.

PROGRAM FEATURES

A streamlined scientific program was used at the 1950 meeting—condensing into less than three days 13 lectures, six discussion periods on Medical Topics of the Day, 14 Instructional Courses and other features of medical educational value to doctors.

All scientific sessions were well attended. The general sessions drew as many as 400 and more doctors per session. Between 250 and 300 was perhaps an average. Instructional Courses, where informality was the rule, were attended by between 50 and 85 doctors per course. The sessions on Medical Topics of the Day ranged in attendance from approximately 100 to approximately 240 doctors.

The general session on National Affairs at which Dr. George F. Lull, secretary and general manager of the A. M. A., spoke, and at which a recording of an address by the Honorable Robert A. Taft was heard by the audience, was the best attended of all meetings. The auditorium which seats approximately 1,350 was filled almost to capacity. Senator Taft had to cancel his speaking engagement the morning of the session because of the illness of Mrs. Taft.

THE COUNCIL AND HOUSE OF DELEGATES

The Council met in regular session on Monday, May 15, on the eve of the Annual Meeting. Proceedings of the business transacted at this meeting are reported elsewhere in this issue. A special meeting of The Council was called by the Incoming President immediately after the final meeting of the House of Delegates. Minutes of this meeting, which has to do principally with appointments of committee members, is contained in the Proceedings of The Council.

The House of Delegates held its first meeting on Tuesday morning, May 16, with luncheon at the Cleveland Hotel. The final meeting was held in the same hotel on Thursday, May 18. Proceedings of these meetings in which are established policies of the Association are recorded in the article, Proceedings of the House of Delegates, which will be found elsewhere in this issue.

Election of officers, a function of the House of Delegates, will be found in the minutes of the House of Delegates, while biographical data on the new officers will be found in a special article beginning on page 692.

THE BANQUET

The annual banquet on Wednesday night, in the midst of a concentrated scientific and business program, furnished a refreshing evening for members and their guests. The dinner, followed by an evening of entertainment and dancing, was held in the ballroom of the Hotel Cleveland. Approximately 500 persons enjoyed this event. Entertainment was in the form of a variety show.

During the banquet Dr. A. A. Brindley, past-president, presented Dr. Carl A. Lincke, retiring president, with a replica of the official gavel used during his year in office.

PUBLIC RELATIONS

In addition to notices sent out from the Headquarters Office, the public press and radio stations cooperated very well in furnishing the public with information about the meeting and its many activities. The Association's Public Relations Department through advance releases and by special announcements as the meeting developed kept the public informed.

The meeting was especially well covered by special medical and health reporters for the local newspapers. Severino P. Severino of the *Cleveland News*, Walter Lerch of the *Cleveland Press*, and Mrs. Josephine Robertson of the *Cleveland Plain Dealer*, each covered many features of the meeting and wrote special articles.

Dr. George F. Lull, secretary and general manager of the A. M. A., was interviewed on a television news program over Station WNBK by Edward Wallace, well-known Cleveland news commentator and former foreign correspondent for NBC. The subject of discussion was the educational program of the medical profession against compulsory health insurance and other forms of socialized medicine.

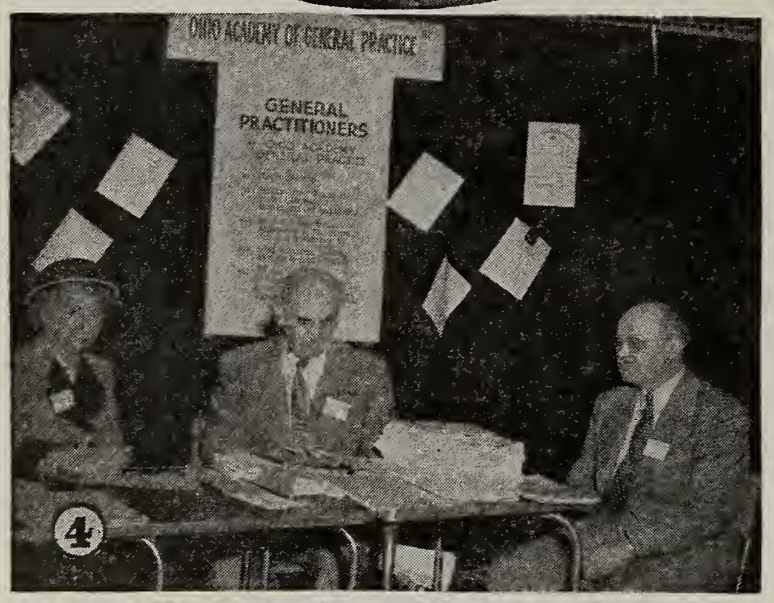
Mr. George H. Saville, public relations director for the Association, gave a daily roundup of the program for rebroadcast over Station WJMO at 6:20 p. m. each day. Mr. Saville gave these reports over the telephone to the studio where they were recorded. The rebroadcasts formed

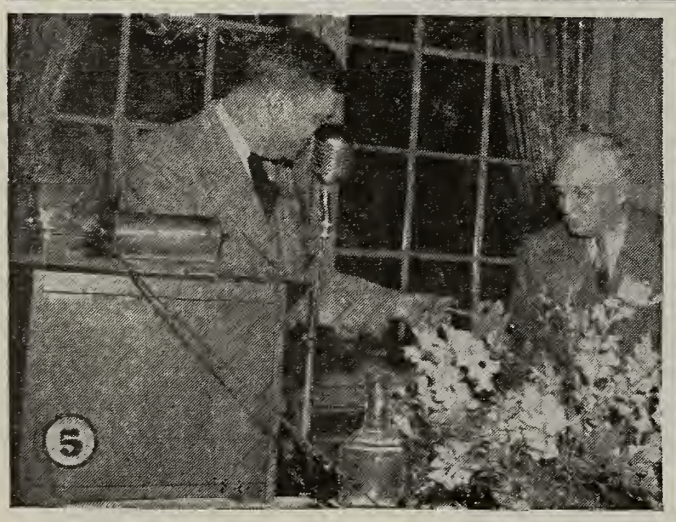
Some of the High Spots at Annual Meeting













1. Dr. Arthur T. Evans (left), one of the sponsors, explains phases of the first prize scientific exhibit, "Translumbar Arteriography."

2. Dr. George F. Lull (left), secretary and general manager of the A. M. A., and Dr. C. C. Sherburne, Columbus, pause before the Association's booth in a tour of the exhibit hall.

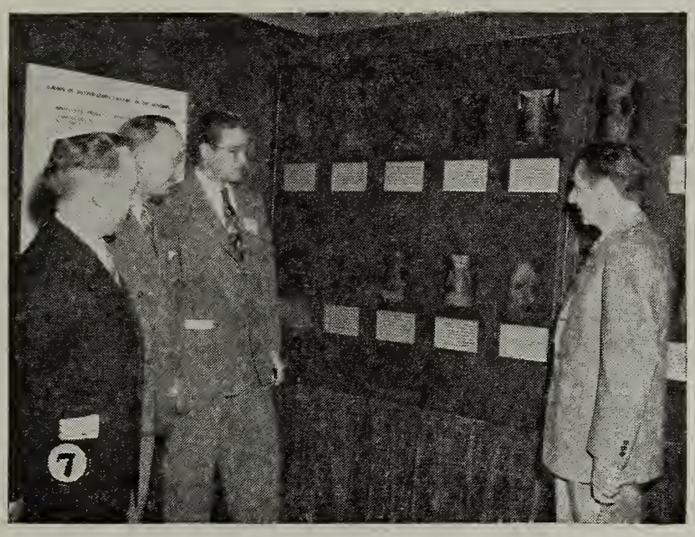
3. Dr. Fred W. Dixon (facing camera), shows specimens of his exhibit "Nasal Sinuses" which won second place.

4. Dr. Earl D. McCallister (right), secretary-treasurer of the Ohio Academy of General Practice, assisted by Mrs. Ruth Hukill, discuss matters with a visiting doctor in the Academy's booth.

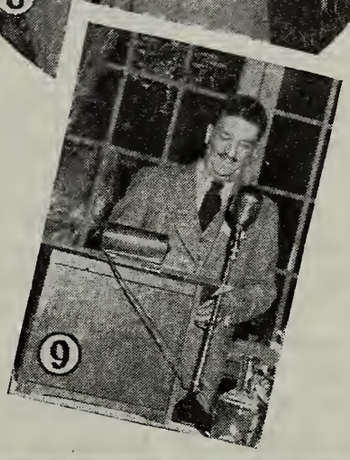
5. Retiring President Carl A. Lincke passes the gavel to Incoming President E. O. Swartz.

6. This capacity crowd heard Dr. Lull as he spoke on "Your A. M. A. and Its Activities."

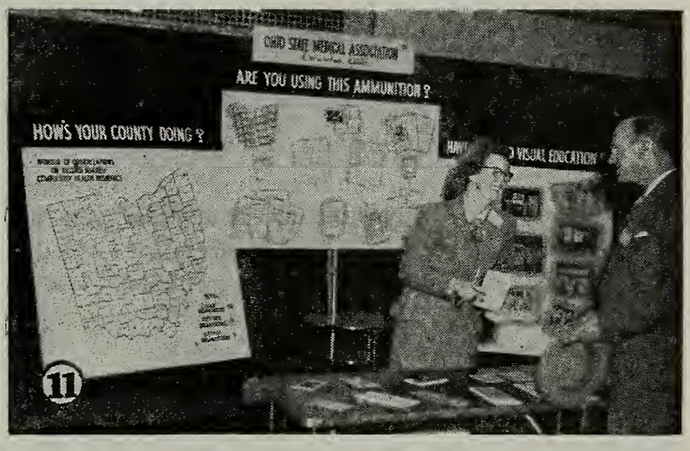
Camera Catches a Few of Many Activities

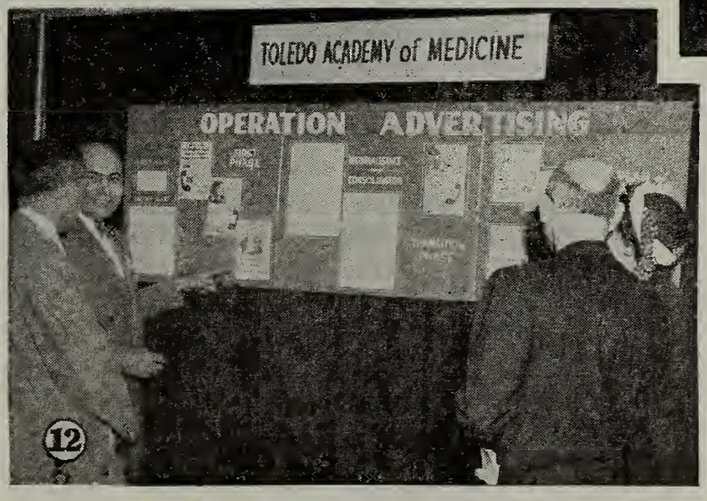














7. Dr. Karl P. Klassen (right) and Dr. Douglas R. Mor n (third from left) explain exhibit "The Surgical Management of Intrathoracic Abnormalities of the Newborn," which won third place.

8. Dr. Sherburne (right) escorts President-Elect Fred W. Dixon to the stand after his election by the House of Delegates. At left is retiring president, Dr. Lincke.

9. Dr. Lincke is shown as he delivered the "President's Address."

10. This group from Toledo enjoy a social moment betwe n dances after Annual Banquet.

11. Mrs. Ora Winzenreid of the Columbus Headquarters Office, is showing a visitor campaign literature. Such "ammunition" is always available through the Columbus Office.

12. This booth sponsored by the Toledo Academy of Medi ine shows what that Academy is doing to publicize its emergency call service.

13. Dancing was enjoyed by many following the Banquet and special entertainment features.

part of the program conducted by Bill Kennedy, newscaster.

SCIENTIFIC EXHIBITS

One of the best arrays of scientific exhibits ever seen at an Annual Meeting was on hand for doctors. There was a total of 37 of these exhibits, each representing a special project in medical research developed by a doctor or team of doctors.

Dr. Charles L. Hudson, Cleveland, chairman of the subcommittee on scientific exhibits, was highly commended in behalf of himself and his committee for the untiring work exerted in arranging the educational feature.

AWARD WINNERS

Prize winning awards in the form of certificates of recognition for outstanding scientific exhibits were made again this year, by an anonymous committee appointed by the President.

The committee named a first, second and third place exhibit and also gave honorable mention to a fourth exhibit. The winning exhibits were:

First Place—The exhibit on **"Translumbar Arteriography,"** sponsored by Dr. Parke G. Smith, Dr. T. W. Rush and Dr. Arthur T. Evans, all of the Division of Urology, University of Cincinnati College of Medicine.

Second Place—The exhibit on **"Nasal Sinuses,"** sponsored by Dr. Fred W. Dixon, Department of Otolaryngology, Western Reserve University School of Medicine, Cleveland.

Third Place—The exhibit on **"The Surgical Management of Intrathoracic Abnormalities of the Newborn,"** sponsored by Dr. Karl P. Klassen and Dr. Douglas R. Morton, Department of Research Surgery, Ohio State University College of Medicine, Columbus.

Honorable Mention—The exhibit on **"Fluoroscopic Spot-Film Technique in Cholecystography,"** sponsored by Dr. Mortimer Lubert and Dr. George Krause, Department of Radiology, Mount Sinai Hospital, Cleveland.

The winning exhibits were recognized by a plaque placed in the respective booths and by a certificate sent out from the Headquarters Office.

There were 37 scientific exhibits at the meeting, all of which drew a great deal of interest from visiting doctors.

TECHNICAL EXHIBITS

A large and most interesting display of technical exhibits was presented. The commercial exhibits were in the Main Arena of the Cleveland Public Auditorium. Time was allowed between scientific sessions for doctors to visit these exhibits and gain much information on what is on the market in the way of pharmaceuticals, equipment, instruments and other supplies used by the medical profession. The Auditorium was an ideal place for the exhibits with ample room for doctors to visit with representatives of the supply houses.

HIGH LIGHTS AND SIDE LIGHTS

Dr. Herbert B. Wright, president of the Cleveland Academy of Medicine, representing the host organization, officially opened the meeting of the House of Delegates and welcomed visiting doctors to Cleveland.

* * *

The Council adjourned to meet on Friday, Saturday and Sunday, September 15-17, at the Granville Inn. This extended meeting is scheduled to take care of a very heavy docket which always accumulates over the summer months.

* * *

The Annual Meeting of the Woman's Auxiliary to the Ohio State Medical Association was held at the Hotel Cleveland, concurrently with the Association's meeting. Officers and representatives of County Auxiliaries reported another successful season. Complete report of the meeting will be found elsewhere in this issue.

* * *

Dr. Harry V. Paryzek, general chairman of the Cleveland Committee for the Annual Meeting, was unable to be present at the meeting because of illness.

* * *

Dr. Carroll C. Dundon, chairman of the Committee on Halls and Meeting Places, among other things arranged to have a reception committee at the door of each meeting place for every meeting. These consisted of interns and residents of local hospitals.

* * *

Dr. G. W. Crile, Jr., chairman of the Reception Committee, arranged to have a member of the committee meet and help entertain each guest speaker on the program. This did much to make the out-of-state speakers feel right at home during their stay in Cleveland.

* * *

The entire regular staff of the Columbus Headquarters Office was at the Annual Meeting helping to attend the many behind-the-scenes details which make such a large meeting run smoothly. Registration was handled by the staff with the help of personnel furnished by the Cleveland Convention Bureau.

* * *

The Cleveland Academy of Medicine operated an emergency call service for doctors attending the meeting. Emergency calls were handled by bulletin board announcements and page service.

* * *

A public address system with loudspeakers in the Main Area helped much in announcing sessions, relaying emergency calls and giving other announcements.

National Affairs . . .

Senator Taft in Re-broadcast Address Knocks Proposals on Socialized Medicine; Dr. Lull Tells What A. M. A. Is Doing On National Scene

DOCTORS who attended the Annual Meeting had the opportunity of hearing the Honorable Robert A. Taft's sentiments on Socialized Medicine even though the Senator was unable to be present to deliver his scheduled address because of pressing legislative matters coupled with the sudden illness of his wife.

He was scheduled to speak on "Progress in Medical Care." Fortunately a recording of the address Senator Taft had given the previous evening over a nation-wide hookup was obtained and was rebroadcast over the public address system for listening doctors. Because Senator Taft touched heavily upon the subject of socialized medicine in his address, it was particularly appropriate for the occasion.

Senator Taft's talk was a challenging answer to speeches made by the President on his tour of the Nation. Mr. Taft had this to say about the proposed national medical program:

SOCIALIZED MEDICINE

"Then we have the program of socialized and nationalized medicine on which the President is treading pretty lightly on this trip. But he has heretofore endorsed it three times enthusiastically, and we can assume that if he ever gets a Congress which will do his bidding and that of the C. I. O. - P. A. C. he will return to his first love. He proposed that we levy for this purpose another six billion dollars of taxes, set up a vast Federal bureau to employ all the doctors and all the hospitals in the United States to give medical care to 150,000,000 people, including all those who are perfectly able to pay for it themselves.

"It would destroy, of course, the freedom of the medical profession and supersede entirely the tremendous system of community and charitable health service which has given this country the best health of any comparable country in the world.

"Do you want a Congress that will go out and spend that six billion dollars more?"

GOOSE STEP MEDICINE

Again Ohio's Senior Senator warned what would be in store if socialized medicine were voted into existence. "Under the medical plan, every family must be told by detailed regulation just what kind of medical service it can get and what it can't get. Mr. Truman attacked the Eightieth Congress because it refused to give him power to fix prices and fix wages and allocate and ration commodities, all the old O. P. A. powers of wartime—'police state controls,' he called them himself . . .

"We believe that hardship and poverty can be eliminated in America without extending Government welfare service and regulation to the entire population," Senator Taft continued, "for such universal free service can bankrupt the Government while it destroys the freedom and the character of the people to whom it is extended.

"If we hope to progress in the future as we have in the past, we can only do so if we elect a free Congress, one which will carry out on its own independent initiative a program of progress based on the principles of liberty and justice and equality on which this nation was founded."

REPUBLICAN PLATFORM

Senator Taft assured that a Republican Congress will "back up Mr. Truman or any other President in his foreign policy, as far as they stand four square against the spread of communism anywhere in the world. It will welcome any efforts toward peace which he deems to be practical by direct negotiations with the Russian leaders. It will provide an all-powerful armed force for the United States. It will insist on elimination from Government, and particularly from the State Department policy-making group, of every man who thinks that communism has about it any of the elements of true Americanism."

In denouncing what he termed "the political immorality" of the present administration, Senator Taft said: "What is the program as shown by the speeches (of Mr. Truman) of this past week? A part of it, of course, is just irresponsible promising."

DR. LULL

Dr. George F. Lull, secretary and general manager of the A. M. A., keynoted the effect of the medical profession's educational program when he said that Federal Security Administrator Oscar Ewing and other promoters of the National Compulsory Health Insurance program are "worried as hell."

The National Affairs program at which Dr. Lull spoke and the rebroadcast of Senator Taft's address was heard, was attended by approximately 1,100 doctors. Dr. Lull spoke on the subject, "Your A. M. A. and Its Activities."

His conclusions on the apprehensions of "Welfare Oscar," as the speaker called him, were based partly on experiences at a Jefferson Jubilee celebration staged in Chicago by Democratic

bigwigs. During this celebration, Administrator Ewing staged what he called a panel discussion on government health insurance. However, Dr. Lull pointed out, this turned out to be nothing more than a big rally by Democratic national committeemen for socialized medicine.

Almost the entire session, Dr. Lull said, was taken up with vicious and insulting attacks on the A. M. A., although he and other representatives of the medical profession were not permitted to answer the accusations.

Supporting speakers included Representative Andrew J. Biemiller, Milwaukee; Nelson Cruikshank, director of the A. F. L. social insurance activities; and Dr. Theodore M. Sanders of New York; all well-known supporters of the administration's welfare program.

"It was supposed to be an open panel," Dr. Lull said, "but the supporting speakers were 'the same old crew.'

"I never saw such pain as there was on the face of Dr. Paul R. Hawley (director of the American College of Surgeons). It was absurd to have to sit there and not be able to speak for your cause." Finally he and other representatives of the medical profession walked out, Dr. Lull said.

"They tried to influence people to believe that the country's health is in a terrible state, but if you read Mr. Ewing's own statistics you will see that this Nation has better health than any other." Oscar Ewing, the speaker said, is bitter about the A. M. A. because it prevented him from becoming a cabinet officer by defeating his Reorganization Plan No. 1.

OTHER ACTIVITIES

Dr. Lull pointed out that the educational program to further voluntary health insurance and combat government control of medicine is only one phase of the A. M. A.'s many activities.

The speaker then reviewed some of the activities, high lighting such projects as the periodic examination of medical schools; expansion of the Washington office; publication of the *Quarterly Cumulative Index*, a vital factor in medical research; publication of *Today's Health* for the education of the lay public.

'UNTIRING WORK'

As an example of the work in behalf of medicine being carried on by the many councils, committees and bureaus of the A. M. A., Dr. Lull commended the efforts of Ohio's late Dr. Roscoe G. Leland, for many years director of the Bureau of Medical Economic Research. "Dr. Leland was a casualty of the War," Dr. Lull said, adding that his untiring work and long hours during the war constituted the underlying cause of his untimely death.

At present, the speaker said, the Bureau of Medical Economic Research is working with the Brookings Institute in making a survey of medical services throughout the Nation. He predicted that the results of the survey would show that 98 per cent of the accusations of the New Deal administration about the shortage of medical care are not true. The A. M. A. is aware that there are shortages of medical care in some places, Dr. Lull said, but, he added, it is also true that in these same places there are equal shortages of other economic factors that are considered necessary to maintain standards of living.

Dr. Lull warned about "fringe legislation." Now that the medical profession and the public are alerted, he said, the advocates of socialized medicine probably will not try to put over their program in one package. But they will try to put it over little by little. As an example he pointed to the school health program which in itself is a good thing. But, he pointed out, the A. M. A. objects to the bill in its present form because it provides for free medical examinations to all children regardless of the ability of their families to pay. That provision is a form of socialized medicine, he said.

Regional Meeting, American College of Physicians

On November 18, 1950, the American College of Physicians North Central Regional Meeting will be held in Madison, Wisconsin. Registration will begin at 8:00 a. m. and the meeting will consist of a series of scientific papers presented throughout the day. A scientific exhibit of wide general interest is planned in connection with the meeting.

It is to be especially noted that this postgraduate instructional session is open to all interested physicians whether or not they are members of the American College of Physicians. Members of the College are urged to bring along their colleagues as guests.

Dr. Alexander Brunschwig, Memorial Hospital, New York, was guest speaker at the May 11 meeting of the Fort Steuben Academy of Medicine. His subject was "Recent Advances of Surgical Treatment for the Recurrent Cancer of the Uterus After Radiation Treatment." Dr. Joseph A. Hepp, University of Pittsburgh, opened discussion on Dr. Brunschwig's paper.

The Cincinnati Medical Women's Club, Branch 11, A. M. W. A., held its May 23 meeting at the Hyde Park Country Club with seven senior women medical students of the University of Cincinnati College of Medicine as guests. Dr. Mabel Gardner, Middletown, spoke on the subject, "Quo Vadis?" Twenty persons attended the meeting.

Annual Meeting Again Sets Record . . .

All-Time High in Total Attendance and Number of Members Present Is Established at Cleveland; Names of Members Present Reported

AGAIN this year an all-time record for attendance was set at the 1950 Annual Meeting of the Ohio State Medical Association held in Cleveland, May 16-18.

The record applied to number of members as well as to total attendance. The total number present was 3,032 with the following breakdown: Members, 1,587; out-of-state physicians, 13; interns, residents and Ohio guest physicians, 247; medical students, 102; exhibitors, 376; Woman's Auxiliary, 293; miscellaneous guests, 414.

Following are registration figures for the Annual Meetings held from 1919 through 1950; also a breakdown of membership registration by counties, and a list of names of members who registered.

Registration, 1950 Annual Meeting by Counties and Membership Data

County	Total Membership Dec. 31, 1949	Total Membership May 15, 1950	Annual Meeting Registration
Adams	8	8	2
Allen	89	89	13
Ashland	26	26	9
Ashtabula	51	52	12
Athens	34	30	3
Auglaize	16	18	4
Belmont	50	51	7
Brown	5	8	1
Butler	121	117	11
Carroll	9	9	5
Champaign	19	19	3
Clark	109	112	11
Clermont	26	26	3
Clinton	19	18	5
Columbiana	68	66	17
Coshocton	22	23	7
Crawford	32	32	12
Cuyahoga	1,657	1,597	588
Darke	23	26	3
Defiance	15	16	2
Delaware	19	20	2
Erie	42	48	13
Fairfield	42	45	9
Fayette	12	10	4
Franklin	658	655	99
Fulton	18	19	1
Gallia	21	19	2
Geauga	12	12	4
Greene	37	36	3
Guernsey	27	25	2
Hamilton	954	947	52
Hancock	38	37	8
Hardin	28	26	2
Harrison	12	10	3
Henry	11	11	1
Highland	22	20	8
Hocking	11	11	4
Holmes	9	9	6
Huron	25	24	12
Jackson	14	14	1
Jefferson	57	58	4
Knox	32	31	10
Lake	35	39	20
Lawrence	23	23	2
Licking	56	57	15
Logan	22	23	2
Lorain	126	119	57
Lucas	441	439	53
Madison	13	13	1
Mahoning	239	231	39
Marion	49	46	10
Medina	31	29	18
Meigs	12	11	1
Mercer	18	15	2
Miami	44	44	13
Monroe	4	4	1
Montgomery	385	367	38
Morgan	7	6	1
Morrow	8	8	3
Muskingum	54	52	8
Noble	3	3	----
Ottawa	18	17	4
Paulding	10	9	1
Perry	14	13	1
Pickaway	16	15	2
Pike	9	9	1
Portage	33	31	12
Preble	13	13	1
Putnam	19	15	2
Richland	98	95	24
Ross	44	43	11
Sandusky	41	43	10
Scioto	69	69	12
Seneca	42	42	9
Shelby	18	19	2
Stark	267	262	76
Summit	352	343	95
Trumbull	95	97	25
Tuscarawas	52	51	13
Union	14	13	7
Van Wert	24	19	3
Vinton	3	2	1
Warren	17	16	1
Washington	30	28	3
Wayne	46	51	6
Williams	16	17	2
Wood	34	33	9
Wyandot	15	14	2
Totals	7,479	7,338	1,587

Annual Meeting Registration For 1919-1950, Inclusive

Year	Place	Members	Out-of-State Physicians	Guests	Technical Exhibitors	Total
1919	Columbus	1173	10	264	92	1539
1920	Toledo	860	17	105	80	1062
1921	Columbus	1275	28	104	96	1503
1922	Cincinnati	1066	21	184	70	1341
1923	Dayton	1117	19	202	76	1414
1924	Cleveland	1301	13	180	109	1603
1925	Columbus	1204	17	361	107	1689
1926	Toledo	903	19	120	83	1125
1927	Columbus	1320	17	286	82	1705
1928	Cincinnati	916	27	92	80	1115
1929	Cleveland	1231	15	249	124	1619
1930	Columbus	1241	13	435	86	1775
1931	Toledo	826	13	198	50	1087
1932	Dayton	978	2	201	45	1226
1933	Akron	858	6	160	25	1049
1934	Columbus	1069	9	410	51	1539
1935	Cincinnati	973	17	197	84	1271
1936	Cleveland	1099	14	563	137	1813
1937	Dayton	1103	18	366	64	1551
1938	Columbus	1330	15	619	104	2068
1939	Toledo	1056	15	271	84	1426
1940	Cincinnati	1126	26	323	114	1589
1941	Cleveland—Joint Meeting with A. M. A.					
1942	Columbus	1221	13	527	119	1880
1943	Columbus	544	13	160	----	717
1944	Columbus	830	20	441	130	1421
1945	No Meeting					
1946	Columbus	1262	23	679	157	2121
1947	Cleveland	1502	23	561	328	2414
1948	Cincinnati	1362	43	768	214	2387
1949	Columbus	1533	36	809	230	2608
1950	Cleveland	1587	13	1056	376	3032

Members of State Association Registered at 1950 Meeting

Adams County—S. J. Ellison, Hazel L. Sproull.

Allen County—Walter C. Beery, Margaret E. Belt, F. P. Berlin, K. G. Hawver, Charles H. Leech, W. B. Light, Walter A. Noble, J. S. Novello, F. D. Rodabaugh, H. L. Stelzer, Roger L. Tecklenberg, H. A. Thomas, Edward B. Young.

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Auglaize County—Clyde W. Berry, E. F. Heffner, E. Y. Kuffner, Guy E. Noble.

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Brown County—Glenn S. Lamkin.

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Monroe County—J. C. Pugh.

Montgomery County—Irwin H. Altenburg, Sterling H. Ashmun, Robert C. Austin, R. K. Bartholomew, Roy S. Binkley, A. V. Black, Russell N. Brown, Herbert L. Brumbaugh, Orville B. Burke, A. W. Carley, E. F. Conlogue, Sydney Dinkin, Roscius C. Doan, R. Dean Dooley, G. L. Erbaugh, M. R. Haley, Wm. H. Hanning, Albert Hirsheimer, Mason S. Jones, P. H. Kilbourne, Kenneth Kurtz, Jesse P. Kuperman, Howard Lauer, T. L. Light, W. R. Love, V. H. Mahan, Robert C. Markey, M. B. Menke, T. E. Newell, Neal C. Perkins, Merrill D. Prugh, L. Everett Seyler, E. W. Shank, Paul J. Shank, Clyde B. Simson, E. W. Smith, W. B. Taggart, Robert E. Zipf.

Morgan County—Mary C. Gatewood.

Morrow County—F. M. Hartsook, Joseph P. Ingmire, F. H. Sweeney.

Muskingum County—W. B. Devine, P. H. Elliott, A. C. Lawrence, George C. Malley, James McCormick, Flora M. Pedicord, W. W. Renner, Earl B. Zurbrugg.

Ottawa County—H. O. Beeman, Gordon R. Ley, George A. Poe, Cyrus R. Wood.

Paulding County—D. E. Farling.

Perry County—O. D. Ball.

Pickaway County—M. D. Gamble, W. F. Heine.

Pike County—R. M. Andre.

Portage County—Myrtle V. Collins-Dineen, Robert Dumm, Edgar A. Knowlton, Walter W. Lang, Edward T. Meacham, Ray T. Odell, M. S. Owen, J. M. Painter, S. B. Peters, Max Sternlieb, Myron W. Thomas, C. C. Voorhis.

Preble County—E. P. Trittschuh.

Putnam County—H. A. Neiswander, W. B. Recker.

Richland County—Russell H. Barnes, W. M. Bell, P. A. Blackstone, Wallace H. Buker, Charles O. Butner, R. D. Campbell, Darrell B. Faust, Robert L. Garber, Charles L. Hannum, J. S. Hattery, F. J. Heringhaus, H. G. Knierim, E. Mainzer, Lizabeth J. Mainzer, John F. McHugh, Robert J. Peirce, W. W. Peirce, Carl M. Quick, Stanley C. Schiller, Charles L. Shafer, P. O. Staker, J. L. Stevens, Harry Wain, Ralph C. Wise.

Ross County—Edwin H. Artman, Richard L. Counts, Harold Crumley, John W. Franklin, L. T. Franklin, R. P. Giesler, W. E. Kramer, A. E. Merkle, Robert E. Swank, Adolph Wolff, G. Howard Wood.

Sandusky County—C. M. Cooper, Chester G. Egger, R. Allen Eyestone, C. L. Fox, John J. Gedert, John W. Monahan, Allen P. Newman, L. A. Pokerr, Anthony C. Rini, Richard R. Wilson.

Scioto County—George D. Blume, Walter A. Braunlin, Louis R. Chaboudy, Clyde W. Everett, Wm. J. Hartlage, L. B. Hatch, A. P. Hunt, Ralph W. Lewis, Elizabeth Long, J. P. McAfee, Oral D. Tatje, Charles S. Vinson.

Seneca County—Henry Lyman Abbott, W. R. Funderburg, Paul J. Leahy, E. F. Ley, Wilbur W. Lucas, R. F. Machamer, D. J. Mariea, F. H. Pennell, R. E. Schriner.

Shelby County—H. Eugene Crimm, John H. Kerrigan.

Stark County—L. E. Anderson, Walter H. Angerman, J. E. Aten, William D. Baker, Hiram J. Bazzoli, F. P. Bennett, H. H. Bowman, A. E. Boyles, H. H. Brueckner, Joseph J. Brumbaugh, Roy H. Clunk, Cleon C. Couch, Florian P. Cuthbert, John E. Dougherty, F. J. Ebstein, William E. Elliott, D. T. Feiman, S. J. Feingold, L. L. Frick, Verl Z. Garster, Frank O. Goodnough, R. E. Hall, I. B. Hamilton, Ronald M. Harner, Jack G. G. Hendershot, Mark G. Herbst, Arthur G. Hyde, John Dueber Joliet, Douglass S. King, George L. King, Wm. T. Krichbaum, C. A. LaMont, Loyal E. Leavenworth, Karl L. Lehmiller, Joseph J. Leven.

W. B. Malloy, John L. Maple, Joseph W. Mason, Auren W. McConkey, Wm. A. McCrea, J. C. McDonald, James A. McNalley, R. E. Meacham, Ray R. Mosely, Myrl D. Musgrave, Howard S. Myers, Keith C. Noble, Atlee R. Olmstead, C. O. Paradis, Otto L. Plaut, J. Edwin Purdy, R. K. Ramsayer, R. L. Rutledge, Raymond

T. Saxen, Frank M. Sayre, John R. Seesholtz, William J. Slasor, L. M. Snively, John M. Thomas, G. Otho Thompson, R. L. Thompson, John M. Tondra, G. D. Underwood, John J. Underwood.

John M. Van Dyke, J. B. Walker, C. A. Watson, Harry L. Weaver, Homer V. Weaver, Louis L. Weiss, George N. Wenger, G. M. Wilcoxon, Albert Wild, J. S. Williams, O. G. Wilson, R. E. Wirtz.

Summit County—Paul R. Adams, Harry Anker, P. Z. Arapakis, John Bakos, Roy Barnwell, C. M. L. Beatty, Harry S. Berlesky, E. R. Blower, Frank H. Bly, M. F. Bossart, John L. Brickwede, John D. Brumbaugh, Wendell T. Bucher, Earl W. Burgner, Ernest J. Burrows, James T. Cunningham, D. D. Daniels, P. A. Davis, William Davis, Philip B. DeMaine, Arthur Dobkin, Frank V. Dunderman, W. H. Falor, George A. Ferguson, A. W. Friend, Theodore V. Gerlinger, Arnold V. Gold, Nathan G. Gordon, R. A. Gregg, Kenneth F. Hausfeld, Sydney J. Havre, Joseph D. Hayden, John F. Henderson, Carrie A. Herring, E. F. Hurteau.

Wendell E. James, Uffe T. Jensen, N. A. Johnson, Roy F. Jolley, Morris Kalmon, Warren P. Kilway, James G. Kramer, Theodore A. Krutky, Donald E. Leonard, H. G. Lieberman, C. N. Long, George A. Lucas, J. A. Masaryk, C. T. McCormish, R. G. McCready, D. M. McDonald, L. B. Mehl, S. J. Michaels, Samuel Miller, Margaret H. Moore, H. E. Muller, B. E. Neiswander, Carl C. Nohe.

George A. Palmer, G. K. Parke, Thayer L. Parry, Edgar C. Pickard, Dallas Pond, George G. Proskauer, Cecil A. Raymond, Fred K. Read, W. R. Rechsteiner, Eleanor J. Rector, L. E. Rector, J. G. Repasky, David J. Roberts, Fowler B. Roberts, Wm. B. Rogers, J. Paul Sauvageot, H. Senné, H. Vern Sharp, Louis Sheinin, Hazel P. Simms, Robert B. Smith, E. J. Snyder, B. O. Sours, N. Tsaloff, Thomas E. Van Sickle, Edward L. Voke, Frank M. Warner, Karl D. Way, Kurt Weidenthal, G. R. Wellwood, M. R. Werner, R. E. Wetzel, Cloyd F. Wharton, Robert E. Williams, Louis A. Witzeman, H. E. Woodbury, A. S. Zervos.

Trumbull County—Allen W. Beale, L. A. Blum, S. A. Brown, Maynard A. Buck, J. H. Caldwell, E. G. Caskey, Morton J. Crow, Amanto P. D'Amore, Paul C. Gauchat, Joseph W. Kohn, Marie B. Krupko, Paul E. Krupko, E. G. Kyle, F. LaCamera, Chas. W. Mathias, D. R. Mathie, R. H. McCaughtry, Henry J. Meister, Clyde W. Muter, Paul E. Noonan, Joseph A. Ralston, Bernard M. Schneider, S. J. Shapiro, Aubrey L. Sparks, Robert J. Willoughby.

Tuscarawas County—James S. Adler, Jay W. Calhoon, Clark M. Dougherty, P. T. Doughten, D. H. Downey, Henry Engel, M. W. Everhard, R. J. Foster, Robert B. Hines, W. E. Hudson, M. William Johnson, Harold F. Wherley, S. H. Winston.

Union County—Walter R. Burt, Fred Callaway, P. D. Longbrake, Malcolm MacIvor, Evert J. Marsh, James M. Snider, Paul R. Zaugg.

Van Wert County—J. R. Jarvis, Roy E. Shell, H. D. Underwood.

Vinton County—H. D. Chamberlain.

Warren County—Orville L. Layman.

Washington County—F. E. Eddy, G. E. Huston, M. S. Muskat.

Wayne County—Lyman A. Adair, E. R. Alexander, Robert A. Anderson, Bernard M. Foster, H. J. Mitchell, Vincent C. Ward.

Williams County—H. R. Mayberry, Paul G. Meckstroth.

Wood County—Daniel R. Barr, Irvin B. Kievit, H. W. Mannhardt, Floyd A. Nassif, Francis J. Nemcik, Paul F. Orr, Roger A. Peatee, L. S. Pugh, William S. Rothe.

Wyandot County—T. A. Ferguson, F. M. Smith.

Report Increase of 2,266 in Physician Population

The net increase in the number of physicians in the United States and its territories and possessions in 1949 was 2,266, according to the 48th Annual Medical Licensure Report of the American Medical Association's Council on Medical Education and Hospitals.

The report, presented by Dr. Donald G. Anderson, secretary of the council, and his assistant, Mrs. Anne Tipner, both of Chicago, appears in the June 3 *Journal of the American Medical Association.*

These official figures indicate that last year 5,866 physicians were licensed for the first time, and thus represent the gross additions to the profession for that year. In 1949 there were 3,600 deaths of physicians reported to the offices of the American Medical Association.

During the year there were 12,181 licenses to practice medicine issued by the medical examining boards of the 48 states, the District of Columbia and the territories and possessions. Ohio licensed 568.

During 1949 there were 5,963 applicants for medical licensure by written examination, of whom 5,219 passed. The candidates examined represented 70 approved medical schools in the United States, nine approved medical schools of Canada, six United States medical schools now extinct, 124 faculties of medicine and two licensing corporations of other countries, six unapproved medical schools in the United States and 10 schools of osteopathy.

Among the 4,675 graduates of approved medical schools in the United States, only 3.2 per cent failed. Of the 737 graduates of faculties of medicine located in countries other than the United States and Canada, 56.7 per cent failed and of the 114 graduates of schools of osteopathy, 42.1 per cent failed. Among the 282 graduates of unapproved medical schools in the United States, 34.7 per cent failed.

Following a study by officers appointed by Ohio's Dr. Richard L. Meiling, director of medical services, Office of the Secretary of Defense, terms designating military hospitals in the various branches of the armed forces are being standardized. Secretary of Defense Louis Johnson issued a directive to that effect.

Auxiliary Annual Meeting . . .

Tenth Anniversary Is Celebrated With Fifty-Nine Organized Groups In State; Officers and Directors Are Named, Committees Appointed

THE annual meeting of the Woman's Auxiliary to the Ohio State Medical Association, held in Cleveland May 16, 17 and 18, was not only the usual, important convention; it was the occasion of the group's tenth anniversary. That tenth anniversary bore witness to a decade of phenomenal growth — in the number of counties organized, in the scope of the activities, in the ever-increasing degree of usefulness to the medical profession.

The Hotel Cleveland provided the spacious, attractive background for the celebration and three-day program. The Cuyahoga County Auxiliary was the efficient hostess, handling a big job smoothly, courteously and enthusiastically, under the expert, guiding hands of Mrs. Farrell Gallagher and Mrs. D. M. Keating, convention co-chairmen. Total registration of auxiliary members at the convention numbered 294.

PROGRAM DETAILS—TUESDAY

Mrs. C. W. Kirkland, state president, called the pre-convention Board meeting together at 9:30 a. m. The officers and chairmen of committees presented their annual reports. At twelve o'clock noon, the luncheon for the Board of Directors was held.

The formal opening note of the convention was sounded at 1:30 in the afternoon when the House of Delegates of the Auxiliary convened, with Mrs. Kirkland presiding. Dr. LeRoy Lawther of the Lakewood Presbyterian Church gave the invocation. Mrs. John L. Stevens presented the pledge of loyalty. Dr. Herbert B. Wright, president of the Cleveland Academy of Medicine, in a gracious address, welcomed the Auxiliary members to Cleveland. The response was given by Mrs. George Wilcoxon, president of the Stark County Auxiliary.

In presenting her report for the year, Mrs. Kirkland, the president, stressed the importance of unceasing vigilance in the fight against socialized medicine; she expressed appreciation and gratitude for the fine cooperation and help that she had received throughout her year. With great pride, she announced that the State of Ohio has 59 organized county auxiliaries. Reports of the other officers and chairmen followed that of Mrs. Kirkland.

The session adjourned at 4:00 p. m. to allow for "sight-seeing time" in Cleveland.

PROGRAM DETAILS—WEDNESDAY

The second session of the House of Delegates was called to order by Mrs. Kirkland at 9:30 a. m. Reports of committee chairmen not given the preceding day were presented. There was the first reading of the Nominating Committee, and the first reading of recommendations of the Board. A challenging and inspiring portion of the program was the brief but comprehensive reports of the district directors and the county presidents, many of which were eloquent tributes to the local groups throughout the state for well-rounded, helpful, worth-while activities.

In special recognition of the 14 new Auxiliaries organized this past year, a simple but impressive little ceremony was held by Mrs. Kirkland. She welcomed the president of each new group, and as each one came forward in acknowledgment, Mrs. George Cooperrider, president-elect, made the presentation of a scarlet carnation, the flower of the State of Ohio.

MEMORIAL SERVICE

At 12:00 o'clock noon, a quietly beautiful "In Memoriam" service was conducted by Mrs. Paul Woodward, vice-president, assisted by Mrs. E. Benjamin Gillette, past-president, and Mrs. Wilcoxon. The opening prayer, set to music and sung by Mrs. Wilcoxon, preceded the ceremonial lighting of 12 tall white tapers by Mrs. Gillette. Each such taper represented a member who had died this past year. The poem of one such member, Mrs. Oliver P. Coe, internationally acclaimed poet, was read by Mrs. Woodward. Another of Mrs. Coe's works which had been set to music provided a fitting "last touch" as the significant words of "At the sound of your key in the door" was softly and movingly sung by Mrs. Wilcoxon.

PRESIDENT'S LUNCHEON

The President's luncheon on Wednesday honored Mrs. Kirkland and Dr. Carl A. Lincke, president of the Ohio State Medical Association. Mrs. Daniels, president-elect of West Virginia, was introduced as was Dr. E. O. Swartz, incoming President of the Ohio State Medical Association, and the three members of the Advisory Board—Dr. H. M. Clodfelter, Dr. Paul A. Davis and Dr. Chester P. Swett.

The guest speaker, Dr. George F. Lull, secretary and general manager of the American Medical Association, gave a forceful talk that urged the doctors' wives to "keep your husbands educated . . . educate the younger people . . . put more emphasis on the positive side—that is, on the voluntary health insurance side . . . talk

to groups who do not think the way we do . . . organize Speakers' Bureaus . . ."

Dr. Clodfelter presented awards to the four winners in the *To-Day's Health* contest, which awards were furnished this year by the Ohio State Medical Association. Lorain County Auxiliary, winner in Group I, also won a first prize of $40 in the *To-Day's Health* contest sponsored by the American Medical Association. Knox County Auxiliary, winner in Group II of the state contest, also won an Honorable Mention in the national contest. Marion County Auxiliary came off with top state honors in Group III, also winning Honorable Mention in the national contest. Stark County Auxiliary topped Group IV in the state contest.

Following the luncheon program, there was a short intermission, after which the round table discussion was held, with its "Questions and Answers" period with state officers and chairmen.

PROGRAM DETAILS—THURSDAY

The third session of the House of Delegates got under way at 9:30 a. m., with the presentation of unfinished reports of district directors and county auxiliary presidents. Unfinished business was next on the agenda, followed by new business and acceptance of the budget. The House of Delegates adopted the Board's recommendation that the nurses' loan scholarship fund be made available to either student or graduate nurses. Thirty-five delegates to the national auxiliary convention in San Francisco were elected. Winners in the Credits and Awards contest were announced, first place going to Ottawa County Auxilary, and second place to Fairfield County Auxilary.

The report of the nominating committee was presented by Mrs. E. Benjamin Gillette, chairman.

NEW OFFICERS AND DIRECTORS

The new officers and directors elected to office include: president, Mrs. George W. Cooperrider, Columbus; president-elect, Mrs. Farrell Gallagher, Lakewood; vice-president, Mrs. E. P. Greenawalt, Springfield; recording secretary, Mrs. Ross Knoble, Sandusky; corresponding secretary, Mrs. Oscar Jepsen, Canal Winchester; treasurer, Mrs. A. Paul Hancuff, Toledo; past-president, Mrs. C. W. Kirkland, Bellaire.

Directors: Mrs. Azel Ames, Jr., Hamilton; Mrs. Harold Messenger, Xenia; Mrs. Harold K. Mouser, Marion; Mrs. Wendell Green, Toledo; Mrs. S. C. Lind, Lakewood; Mrs. Robert Lommon, Akron; Mrs. Carl Goehring, Steubenville; Mrs. D. Reed Jones, Cambridge; Mrs. George Obrist, Portsmouth; Mrs. James Snyder, Marysville; Mrs. C. E. Swanbeck, Huron.

Chairmen of Standing Committees: Legislation, Mrs. Paul Woodward, Cincinnati; Publicity, Mrs. S. L. Meltzer, Portsmouth; Program, Mrs. E. Benjamin Gillette, Toledo; Public Relations, Mrs. N. M. Reiff, Washington Court House; Historian and Archives, Mrs. A. D. Cook, Dayton; *To-Day's Health*, Bulletin and Handbook, Mrs. A. H. Kimmel, Norwalk.

Chairmen of Special Committees: Radio and Visual Education, Mrs. W. R. Gibson, Oak Harbor; Credits and Awards, Mrs. Karl Ritter, Lima; Nurses Loan Fund, Mrs. Lewis B. Stephan; Convention Co-Chairmen, Mrs. Paul Woodward and Mrs. William Lippert, Cincinnati; Editorial Staff, *The Ohio Medical Auxiliary News*: Mrs. S. L. Meltzer, Portsmouth, Editor; Mrs. Gerald H. Castle, Cincinnati, Associate Editor; Mrs. Clyde M. Fitch, Portsmouth, Associate Editor.

The impressive installation of officers was conducted by Mrs. V. E. Holcombe of Charleston, West Virginia, a past-president of the Woman's Auxiliary to the American Medical Association. The convention adjourned after Mrs. Cooperrider gave her vital and informative inaugural address with its pledge of unceasing activity against the threat of socialized medicine. Members of the new Board were introduced.

LUNCHEON FOR NEW PRESIDENT

A luncheon honoring the new president, Mrs. George W. Cooperrider, and her officers, was held at 1:00 p. m., Thursday afternooon. Mrs. Daniels and Mrs. Holcombe were guests of honor at the luncheon. A feature of the luncheon hour was the Fashion Show presented by the Higbee Company of Cleveland. Music was provided by Harry Walker and his orchestra.

A Post-Convention Board meeting followed the luncheon. There are 3,511 paid-up auxiliary members in Ohio, 654 of whom are new members this year.

Ohio State Radiological Society Holds Annual Meeting

The Ohio State Radiological Society at its meeting in Cleveland elected Dr. Arnold D. Piatt, Newark, president for the current year, to succeed Dr. Edward L. Voke, of Akron. Dr. Piatt was vice-president last year.

Other officers elected are Dr. Donald D. Brannan, Cleveland, vice-president, and Dr. Edmond C. Elsey, Cincinnati, secretary-treasurer.

The following executive officers were elected: Dr. Huston F. Fulton, Columbus; Dr. Austin J. Brogan, Dayton; Dr. W. S. Peck, Toledo; Dr. Edward L. Voke, Akron; and Dr. Henry Snow, Dayton.

The Society held its annual meeting on May 17 at the Statler Hotel in Cleveland, during the Annual Meeting of the Ohio State Medical Association. A scientific program was held from 9 a. m. until noon, followed by luncheon and the business meeting.

Are Doctors Citizens?

NOT LONG AGO, one of my patients—a fellow who always has taken an active interest in community affairs—asked me, jokingly: "Doctor, are doctors citizens?"

The question puzzled me. Then, I discovered that he had been reading statistics about the large number of professional and business men who have been slackers when it comes to taking part in political affairs and voting. Of course, my friend was trying to rib me. But, there is enough truth to his question to make physicians sit up and take notice.

Apparently some people are not altogether sure of the answer to the question: "Are doctors citizens?" Some political sources are trying to make the people think that the doctor is different from other citizens; that he has a different sort of civic obligation and a different sort of individual rights. Isn't it about time for the physician to stand up and be counted; to stand up and let the public know that he is a citizen and like other citizens has civic obligations and responsibilities?

The Congressional elections on November 7—in fact, the political campaigns which are now under way—will give the people of Ohio a good yardstick with which to measure the citizenship of the medical profession of Ohio

Is it a citizenship that influences government; a citizenship that is informed about candidates and political issues; a citizenship that means registration, working for able candidates, and voting? Or is it a negative and passive citizenship? Are doctors "too busy" to fight for their citizenship, for the preservation of medical standards; for their professional freedom?

The answer is up to you, Doctor. The testing time is here. It is time for doctors to prove that they are patriotic citizens, fully cognizant of their civic obligations and determined to live up to their great responsibilities.

Sincerely,

E. O. Swartz, M. D.,
President.

5.4 Per Cent of Persons Are Disabled in U. S.

On an average weekday in February 1949 there were about 4,569,000 persons from 14 to 64 years of age in the civilian population of the entire United States disabled by illness or some condition that prevented them from doing anything but occasional part-time work. This does not include persons between these ages in resident institutions or in the armed services. A rough estimate for these two categories brings the total up to 5,310,000, or 5.4 per cent of the population between these ages.—National Tuberculosis Association.

Houston Meeting Contract Signed For A. M. A. Interim Session

The A. M. A. has signed a contract with the City of Houston for the use of the Sam Houston Coliseum and Music Hall in connection with the Fifth Annual A. M. A. Clinical Session in that city, December 4-7, 1951. The two places will be used for the scientific sessions and the scientific and technical exhibits.

The House of Delegates will hold its session at the same time, in one of the larger hotels.

The A. M. A. Clinical Session this year will be held in Denver, November 28-December 1.

More Hill-Burton Hospitals Open . . .

Projects Now in Use at Washington C. H., Nelsonville and Wooster; Others Will Be Ready Soon; 44 Construction Jobs Are Now Approved

TWO more Ohio hospitals constructed under the Hill-Burton Law have been opened. They are the Fayette County Memorial Hospital at Washington C. H. and the Mount Saint Mary Hospital, Nelsonville.

The Fayette County Memorial Hospital was the first hospital project approved for assistance in Ohio under Public Law 725, through which the Federal government grants a percentage of the construction cost. It is in one of 12 areas in Ohio designated as priority A, which means that the area was designated as having zero percentage of acceptable hospital beds.

The hospital design and construction is unique in many respects. It is a one-floor plan built in the form of wing projections. In a recent nation-wide competition on hospital design the project received considerable publicity in *Hospitals*, the journal of the American Hospital Association.

One feature is inclusion of a modern public center in a wing of the building. Under the cooperative program, facilities of the hospital will be availabe to the local health department although administration will be entirely separate from that of the hospital. The architects are Inscho, Brand and Inscho, of Columbus.

The 46-bed hospital has facilities and equipment to take care of approximately 25 additional beds if the need arises. Total cost of construction and equipment was $630,000 of which the Federal government contributed $210,000.

NELSONVILLE HOSPITAL

The Mount Saint Mary Hospital at Nelsonville is a four-floor plan with a capacity of approximately 80 beds. It was built at a cost tentatively estimated at $1,260,000. The Federal government is contributing one-third of the construction and equipment cost.

This hospital designed by Louis F. Karlsberger, Columbus architect, is considered one of finest and most modern in its class. It, too, includes space for the county health department and if necessary a larger district office.

The Mount St. Mary Hospital is under administration of the Sisters of St. Francis, Buffalo Academy of the Sacred Heart.

OTHER PROJECTS

First of the new hospitals under the Hill-Burton Law to open was the Wooster Community Hospital, report of which was carried in the March issue of *The Journal.*

Other projects recently approved for participation under the program and not previously reported in *The Journal* are:

Galion City Hospital; 25-bed addition to increase capacity of present hospital to approximately 60 beds; also new service facilities; tentative estimate, $250,000, of which the Federal government will contribute $50,000; should be under construction by September.

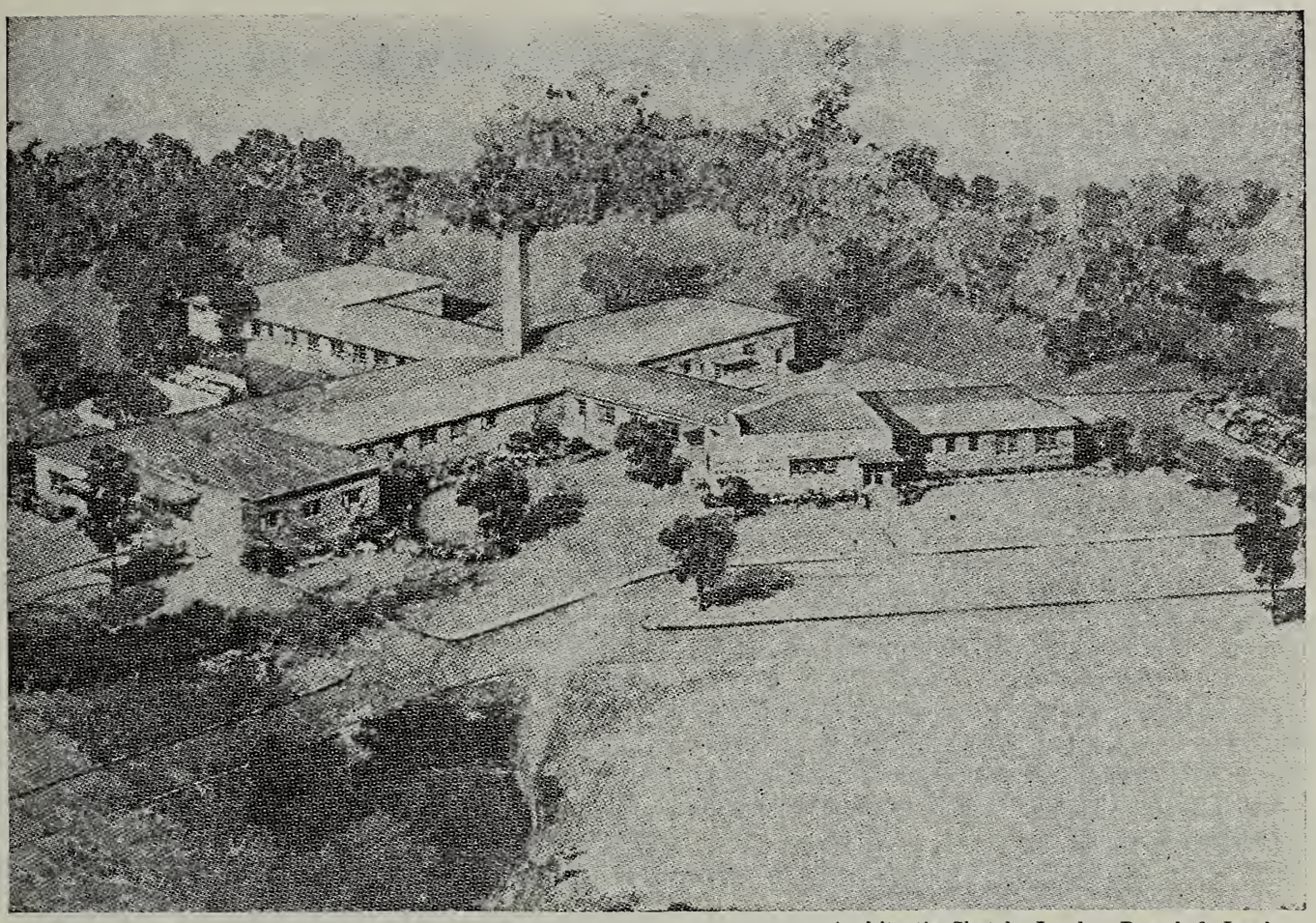
Willard Municipal Hospital; remodeling project now under way will increase present capacity of 32 beds to approximately 55; expected to be completed during this summer. The new project under the Hill-Burton Law is for equipment at a cost of $60,000 of which the Federal government will contribute $20,000.

Mary Mount Hospital, Garfield Heights, Cleveland, a 234 bed hospital. Total estimated cost,



Photo Courtesy The Nelsonville Tribune

This view of the Mount St. Mary Hospital, Nelsonville, shows the four-floor project after its completion.



Architect's Sketch, Inscho, Brand & Inscho

This architect's sketch of the Fayette County Memorial Hospital at Washington C. H. shows how a one-floor plan was used to advantage.

$3,500,000. Federal government will share in cost of equipment only to extent of $26,471.

Bellevue Hospital, Sandusky County; expansion of present hospital to 55 to 60 beds; cost, $336,000 of which Federal share will be $112,000; still in planning stage.

Providence Hospital, Sandusky; approximately 40-bed addition; estimated cost, $810,000 of which Federal share will be $270,000.

Nurses' Residence Project, Mercy Hospital, Portsmouth; estimated cost, $367,800; Federal contribution, $122,600.

St. Vincent's Hospital, Toledo; equipment project for new addition; estimated cost, $375,000 of which Federal government will contribute $125,000.

Samaritan Hospital, Ashland; 35-bed addition; estimated cost $529,500; Federal share, $176,500.

Federal grant-in-aid funds allowed under the Public Law 725 (Hill - Burton Law) are administered in Ohio through the Hospital Facilities Office of the Ohio Department of Health. Anthony J. Borowski, Dr. P. H., is administrator.

Ohio completes its third year of participation under the Hill-Burton Law on June 30 of this year. The program is scheduled to continue through June of 1955. Although many grants are being made to larger hospitals and for additions to existing hospitals, administrators assure that projects in the high priority areas are still on the top of the list for consideration.

Dr. Karsner Heads National Board Of Medical Examiners

Dr. Howard T. Karsner, recently professor of pathology at Western Reserve University School of Medicine, and now medical research advisor to the Surgeon General of the Navy, Washington, D. C., has been elected president of the National Board of Medical Examiners. Other officers elected at the May 3 meeting in Philadelphia are: Everett S. Elwood, executive secretary and treasurer; Dr. J. S. Rodman, medical secretary; and Dr. John P. Hubbard, associate secretary.

The following new members were elected for the regular term of six years: Dr. Chandler McC. Brooks, professor of physiology and head of the department at the State University Medical Center, New York (Long Island Medical College), and Dr. Julian F. DuBois, secretary of the Minnesota State Board of Medical Examiners.

The medical advisory committee to the Montgomery County Chapter of the National Foundation for Infantile Paralysis includes the following doctors: Dr. Robert H. Wahl, chairman; Dr. S. E. Flock, Dr. H. L. MacKinnon, Dr. G. L. Parkin; Dr. Mason Jones, Dr. H. H. Pansing, Dr. Bert Wiley and Dr. F. C. Sutton.

A.M.A. Launches Ad Campaign . . .

New Phase of National Education Campaign Approved by Board of Trustees; Budget Set Up To Place Material in Newspapers, Magazines and on Radio

THE American Medical Association, by unanimous action of its Board of Trustees and Campaign Coordinating Committee, has given the final "go ahead" signal for a Nationwide advertising program which will include three principal media—newspapers, magazines and radio—as a new phase of its National Education Campaign in behalf of Voluntary Health Insurance and against socialized medicine.

Clem Whitaker and Leone Baxter, directors of the A. M. A.'s National Education Campaign, announced authorization of the advertising program and stated that the ad campaign will be launched in October.

A total advertising budget of $1,110,000 has been approved by the A. M. A. Board of Trustees, it was announced, with $560,000 allocated to newspapers, $300,000 to radio and $250,000 to National magazines.

IN EVERY NEWSPAPER

The newspaper advertising schedule calls for blanket-coverage of every bona fide daily and weekly newspaper in the United States—approximately 11,000, in total—and the copy is scheduled to run during the week of October 8. Newspapers in the territories of Hawaii and Alaska will be included in the schedule. The space reservation will approximate 70 inches (probably a 5 x 14) in all papers.

About 30 of the leading National magazines, and a score of advertising trade publications, will be included in the magazine ad program.

The radio advertising program calls for an intensive "spot announcement" campaign, utilizing time on some 300 radio stations, covering every State and Hawaii and Alaska.

The magazine and radio campaigns also are scheduled for October.

TWOFOLD PURPOSE

"This is not an institutional advertising program," said the Whitaker & Baxter announcement. "The American Medical Association is embarking on a Nationwide advertising program for two reasons. First, it is determined to aid in every way possible in increasing the availability of good medical care to the American people through the medium of Voluntary Health Insurance. In that respect, the advertising copy will be designed to make the American people 'health insurance conscious' and to encourage the extension and development of prepaid medical and hospital care as a means of taking the economic shock out of illness. Second, American medicine is determined to alert the American people to the danger of socialized medicine and to the threatening trend toward State Socialism in this country.

INDIVIDUAL FREEDOM

"The ad copy, in part, will be designed to sell a commodity, Voluntary Health Insurance, but not any particular brand or plan. The individual will be encouraged to secure sound coverage in the plan which he feels best suits his individual needs. In its second aspect, the ad copy will be used to mobilize public opinion in support of a basic American ideal—the principle of individual freedom, as opposed to the alien philosophy of a Government-regimented economy."

It was announced that the following advertising agencies have been selected to handle the buying of space and placement of copy:

Lockwood-Shackelford Company for newspaper and magazine media, with Homer J. Buckley & Associates, Inc., affiliated with them.

The Russell M. Seeds Company in the radio field, with the Harry M. Frost Company associated with them.

Life Underwriters' Grants Include Three in Ohio

The life insurance companies of the United States and Canada will give $670,000 to medical schools and other research centers during 1950 for the study of heart disease and the training of research scientists. The awards were approved in May at the annual meeting of the Life Insurance Medical Research Fund, and bring to $3,200,000 the total amount of money given out by the Fund since it was organized late in 1945.

Grants to institutions in aid of research on diseases of the heart and arteries by the Life Insurance Medical Research Fund include the following in Ohio:

The Children's Hospital Research Foundation, Cincinnati, for research by Dr. George M. Guest on the chemistry of the myocardium in diabetic acidosis, $2,625.

University of Cincinnati College of Medicine, for research by Dr. Eugene B. Ferris, Jr., on hypertensive cardiovascular disease, $21,000.

Western Reserve University School of Medicine, Cleveland, for research by Dr. Normand L. Hoerr on the capillary circulation of intra-abdominal organs, $9,450.

Taft Raps Truman Plan . . .

Reorganization Plan 27 Would Create Department of Health, Education And Security, Relegating Health Needs to Whims of Welfare Personnel

SENATOR ROBERT A. TAFT of Ohio took a lusty swing at President Truman's latest move to give more power and authority over health and medical matters to Social Security Administrator Oscar Ewing and elevate Ewing to cabinet status in a statement released by Taft on June 9, opposing Reorganization Plan No. 27 submitted to the Congress by President Truman.

On May 31 the President sent a reorganization plan to Congress creating a Department of Health, Education and Security, (Reorganization Plan No. 27 of 1950). This plan would create a Department of Health, Education and Security with cabinet status.

Under the plan all functions of the Federal Security Administrator will be transferred to the Secretary. Also to be appointed would be an Under Secretary of Health, Education and Security to be appointed by the President and confirmed by the Senate, who would perform such duties as the Secretary would prescribe. An Administrator to the Assistant Secretary would be appointed by the Secretary with the approval of the President under classified Civil Service.

Continued would be the offices of the Surgeon General of the Public Health Service, Commissioner of Education, and Commissioner of Social Security, all of whom would serve subject to requirements of the Secretary pursuant to law. The Surgeon General would hold office for a term of four years and may be appointed from the commissioned regular corps of the Public Health Service.

The Surgeon General and the Commissioners of Education and Social Security would be appointed by the President subject to Senate confirmation.

To serve for an interim of sixty days the President may designate and empower as acting Secretary any person who is an officer of the Federal Security Agency pending the regular appointment and he shall have the title with the prefix "Acting."

LAST YEAR'S PLAN

Last year the President offered Reorganization Plan No. 1 of 1949 providing for a Department of Welfare. The provisions of that plan were almost identical with the new plan except that he substituted for Department of Welfare, the title "Department of Health, Education and Security." In the latest plan express provisions retain for the Surgeon General and Commissioner of Education statutory authority and duties now vested in them.

Under the law a constitutional majority of either the House or the Senate may kill this plan if they take appropriate action before the expiration of sixty calendar days. In other words this plan would become law if neither House voted it down prior to July 31, providing both Houses stay in session until that date.

TAFT'S STATEMENT

Following is the text of Senator Taft's statement in which he points out the bugs in the Truman proposal.

"The Proposal to create a Department of Health, Education and Security is designed to carry out an idea that has been current for quite a while. In fact, I once introduced a Bill to establish a new department. The difficulty is that Health, Education, and Security are all different subjects. On the local level in cities they are entirely separate departments. The only respect in which they are grouped together in the present Federal Security Administration is that they all are matters in which the Federal interest is secondary and the matter of principal interest is aid to the States.

"Last year a similar plan was presented, and it was defeated in Congress. It was defeated because it did not conform to the Hoover Plan. Hoover recommends setting up a Department of Education and Security. But he wants to put the Health Division in an entirely separate medical administration. That's been the great issue. The welfare people, like Oscar Ewing, want to run health as a kind of welfare service.

"The doctors and others feel that medical care and health is a special subject, which ought to be dealt with by people expert in the health field and not subject to welfare direction. Now, the difficulty with this plan is the same as the difficulty with the plan last year. It is true that it separates these three functions into separate departments under the secretary, but the secretary has an assistant secretary, and an under secretary, all of whom are likely to be welfare people, and then it isn't perfectly clear that all the health functions have to be assigned to the Surgeon General of the Public Health.

SAME OBJECTIONS

"It seems to be that the plan has all the objections which the plan had last year; and,

therefore, I should think under the same circumstances it is likely to be defeated primarily because it does not conform to the Hoover Plan, and, I may say, apparently because Oscar Ewing just would turn the Federal Security Administration into a Government Department and in turn make Oscar Ewing, instead of a Federal Security Administrator, a secretary in the Cabinet. There is a good deal of resentment in Congress about that, too, which is likely to raise more political objection, perhaps, to the plans than the one based entirely on logic."

Ohio physicians who feel that Reorganization Plan No. 27 is not a sound proposal and should be rejected, should write to Senator Taft, congratulating him on his stand in opposition to the plan and request him to work actively against it. Letters also should be sent to Senator John W. Bricker, suggesting that he also vote to reject Plan No. 27.

Family Doctors Outnumber Specialists Two To One

Nearly two out of every three physicians in private practice in this country are family doctors.

This is brought out by the American Medical Association's recent count of physicians in connection with its publication of the 18th edition of the American Medical Directory, according to Frank V. Cargill, Chicago, directory editor.

The new directory shows that the physicians of the United States are in the following classifications: 72,550 are in general practice and 22,976 are in general practice but give some attention to a specialty; 54,891 limit their practice to a specialty; 12,536 are in Federal government service; 9,700 are retired or in fields not related to medicine; 3,737 are in administrative, editorial or other executive positions related to medicine, and 24,887 are interns, resident physicians or full time physicians in hospitals.

The previous directory, issued in 1942, listed the number of physicians in the United States as 180,496. In the 1950 edition the number is 201,277, an increase of 20,781 and an average yearly gain of 2,598 during the last eight years.

California leads in the number gained, with 16,668 physicians in 1950 as compared with 12,365 in 1942, an increase of 4,303. New York state shows a gain of 2,284; Texas, 772; Pennsylvania, 704; Florida, 634; and Massachusetts, 603.

Among the 24 largest cities in the United States, New York City (including Brooklyn) is first in physician population with 17,915 physicians, an increase of 1,244 since 1942. Chicago is second with 7,477, a gain of 294; Philadelphia is third with 4,894, an increase of 649; Los Angeles is fourth with 4,183, a gain of 811, and Boston is fifth with 3,388, a gain of 454.

Two Changes Approved in Workmen's Compensation Fee Schedule

Upon suggestion of the Ohio State Medical Association, two changes in the Workmen's Compensation Fee Schedule have been approved by the Ohio Industrial Commission. They are: (1) An increase in the minimum fee for X-ray reexamination of fingers and toes to $5, and (2) reduction of the period of after-care covered by the flat fee in reconstructive surgical procedure from six months to three months.

Navy Makes Available Data on Atomic Radiation Effects

The Navy's experimental research data concerning certain effects of atomic radiation upon living tissue are being made available to civilian physicians and medical officers of the armed services and Federal agencies under a program announced recently by Rear Admiral Clifford A. Swanson, chief of the Navy Bureau of Medicine and Surgery.

The commanding officer of each Naval hospital has been instructed to arrange with the local county medical society, commanding officers of Armed Forces reserve components and Federal agencies in their areas for interested physicians to join with Navy doctors in the use of study material.

Future plans for supplying additional study material will depend upon the degree of success realized from use of the present material and the measure of interest manifested by those in a position to benefit from the offering.

1951, 1952 Annual Meetings

The House of Delegates voted to change the meeting place of the 1952 Annual Meeting, previously scheduled in Columbus, because experience during the 1949 meeting indicated that facilities are not adequate there to take care of such a large meeting. The 1952 meeting will be held in Cleveland during the month of May. The House then voted to hold the 1953 meeting in Columbus, provided the new Columbus auditorium is completed by that time.

The 1951 Annual Meeting will be held in Cincinnati, April 24, 25 and 26.

Notice was received of the death on May 12 in Atlanta, Ga., of Dr. George Hess, U. S. Public Health Service medical officer. Dr. Hess was at the U. S. Industrial Reformatory in Chillicothe from 1931 through 1933.

"**AMINOPHYLLIN** shares the actions and uses of other theophylline compounds, over which it has the advantage of greater solubility. It is useful as a diuretic and myocardial stimulant for the relief of pulmonary edema or paroxysmal dyspnea of congestive heart failure. . . . Aminophyllin is also useful in the control of Cheyne-Stokes respiration and for the treatment of paroxysms of bronchial asthma or status asthmaticus."

Council on Pharmacy and Chemistry: New and Non-official Remedies, 1949, Xanthine Derivatives, Philadelphia, J. B. Lippincott Company, 1949, p. 323.

Searle AMINOPHYLLIN *

Oral . . .

Parenteral . . .

Rectal Dosage Forms

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

* Contains at least 80% of anhydrous theophylline.

Mahoning County Essay Contest . . .

Three Winners Are Announced Out of 300 Entries on Voluntary System Of Medical Care; Text of Winning Paper by Medical Student Is Given

MORE than 300 essays on the subject, "Why We Should Preserve the Voluntary System of Medical Care in the United States" were submitted by college students of Mahoning County, it was revealed as winners were announced recently by the sponsoring organization, the Mahoning County Medical Society.

The contest was conducted by a committee of the Society consisting of the following members: Dr. C. F. Gustafson, chairman; Dr. E. J. Reilly, Dr. W. M. Skipp, Dr. Stephen W. Ondash, Dr. James Miller and Dr. H. E. Mathay.

The judges were Judge Elmer T. Phillips, Mrs. Charles B. Cushaw, Jr., Roy M. Welch, Sr., Attorney David E. Jones and Mrs. J. C. Foutts.

The contest was open to all college students of Mahoning County except children of physicians.

Supplementing packages of material on socialized medicine which had been furnished to all public high school and college libraries in Ohio by the Department of Public Relations of the Ohio State Medical Association, additional material was provided by the Department to the Mahoning County Medical Society for distribution to contestants.

WINNERS

First prize winner in the contest was Edward M. Miller, Jr., 716 Glacier Heights Road, Youngstown, a freshman in the Ohio State University College of Medicine. Miller graduated from the Chaney High School in Youngstown in 1946, where he was president of the National Honor Society, a member of the National Forensic League, and received the Bausch & Lomb science award and the mathematics award. At Ohio State, he is a member of Phi Eta Sigma, Romophos, Bucket & Dipper, Sphinx, Alpha Epsilon and Phi Beta Kappa. He received his B. A. degree in 1948 and B. S. in 1949. As first prize winner he received a $250 U. S. Savings Bond.

Second prize winner is Henry W. Pierce, 254 Fairgreen Ave., Youngstown. He is a graduate of Rayen School and a freshman at Hiram College where he is working on his B. A. degree. He also won first prize at Rayen School in the essay contest conducted by the Youngstown Area Heart Association, and he won the Edwin S. Gregory award. Second prize was a $100 bond.

Third prize winner is Donald F. Rendinell, 1824 Coronado Ave., Youngstown. He is a graduate of Rayen School, received his B. A. degree at the University of Michigan, and served in the U. S. Navy during the war as a lieutenant. He received his M. S. degree in chemistry at the University of Pennsylvania in 1947 and is now completing his second year at Western Reserve University School of Medicine.

Honorable mention was given to George Geordan, 224 Porter St., N. E., Warren, and to Wilson S. Hamilton, 546 Detroit Ave., Youngstown.

Following is the complete manuscript of the first prize winning essay:

FIRST PRIZE WINNING ESSAY

"Why We Should Preserve the Voluntary System of Medical Care in the United States"

By Edward M. Miller, Jr.

The very basis of our economic greatness is our inalienable *right to choose*. And whether that choice be one of vocation, religion, or personal physician, all are so interrelated that maintaining any one strengthens the others, and forfeiting any one undermines the others.

It is my purpose therefore to set forth here how our freedom of choice is being challenged by insidious attempts to foist state or political medicine upon our unsuspecting citizenry and why we should resolutely defend our present system of personalized care under which America has grown great and strong.

The American medical profession is the best informed, the most highly skilled, the most efficient, the most humanitarian of any country in the world, without exception. In a generation, life expectancy has been increased twenty years. Epidemics have been virtually eliminated. Amazing strides in preventative-curative medicine, surgery and psychiatry have been made. Vast storehouses of knowledge have been compiled. Through individual initiative, backed by private and public philanthropy, the Nation's health *has kept pace with its economy.*

This enviable record of progress—*unmatched elsewhere*—has been achieved in a free and unfettered medical field. Why, then, should anyone want to halt this advance—to substitute a devious system of controls and compulsions, regulated, not by local authorities who know community conditions, but from Washington, by medically inexperienced administrators, motivated by political expediency and self-perpetuating in office?

For years, large groups of Marxian-schooled propagandists have been working zealously



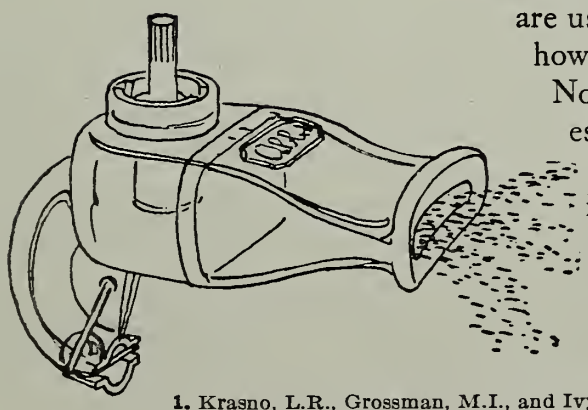
CHRONIC ASTHMATIC

.... Back in Executive Harness

● Many chronic asthmatics have been restored to activity—and maintained that condition—by controlling attacks with NORISODRINE powder inhalation.

Using the Aerohalor®, Abbott's powder inhaler, and a cartridge containing NORISODRINE POWDER, the patient inhales three or four times and the bronchospasm usually ends quickly. This take-it-with-you therapy is effective against mild as well as severe forms of asthma.

Proved by clinical investigation[1,2], NORISODRINE is a bronchodilator with relatively low toxicity. Few side-effects result when the drug is properly administered and these are usually minor. Before prescribing NORISODRINE, however, please write to Abbott Laboratories, North Chicago, Illinois, for literature. This tells how to establish individual dosage and precautions to be taken.



NORISODRINE Sulfate powder 10% and 25% is supplied in multiple-dose Aerohalor* Cartridges, with rubber caps, three to an air-tight vial. The Aerohalor is prescribed separately.

Abbott

*Trade Mark for Abbott Sifter Cartridge

1. Krasno, L.R., Grossman, M.I., and Ivy, A.C. (1949), The Inhalation of l-(3',4'-Dihydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust), J. Allergy, 20:111, March. 2. Krasno, L.R., Grossman, M., and Ivy, A.C. (1948), The Inhalation of Norisodrine Sulfate Dust, Science, 108:476, Oct. 29.

Norisodrine®
Sulfate powder

NOTE THE NAME

(Isopropylarterenol Sulfate, Abbott)

ALWAYS READY FOR USE WHEN THE NEED ARISES

throughout America to disseminate their doctrine of so-called "free" medicine. Their efforts are not based on sincere desire to better our welfare. They seek rather to entrench themselves firmly in a vast system of power and patronage, and thus weaken America's financial stability and threaten her dominance in world affairs.

Such a change in our patient-physician relationship would be far-reaching, disastrous and *irrevocable!* Besides being an encroachment of our Constitutional liberties, it would inevitably result in decreased medical efficiency, dwarf development of self-reliance and personal achievement, attract lower type of students into medicine, reduce patients to bureaucratic submission, and cost the average family *more* than it now spends for medical care.

Government-controlled Medicine has failed abysmally in every country in which it has been tried, including France, Germany, Russia, England. Costs have been stupendous; patients treated on "assembly-line" speed; doctors—badly overworked by queued-up patients—compelled to diagnose and treat in two to four minutes. Patients become "form numbers" instead of individuals. Enormous administrative costs cut sharply into every tax dollar. Heavy abuses reduced each dollar's service still further. Hospitals, over-taxed, were unable to receive *emergency* cases, or aged patients.

Is *this* what our people want? I think *not.* When sickness strikes, they want to *"call* a Doctor"—*Their* Doctor—not wait hours in line for a government appointee.

Then let us keep our Medical Profession *unbound* that it may maintain *responsible* relationship between doctor and patient, better its remarkable achievement record, and continue to serve America *competently! Understandingly! Conscientiously!*

Field Director for A. M. A. Rural Health Committee Named

Mr. Aubrey D. Gates, Little Rock, Ark., is the new field director of the A. M. A.'s Committee on Rural Health which is headed by Dr. F. S. Crockett, Lafayette, Ind. He has been a leave of absence as associate director, cooperative extension work, College of Agriculture, University of Arkansas. He formerly served as a member of the advisory committee of the Committee on Rural Health.

Mr. Gates recently spent considerable time in Columbus studying the setup and program of the Ohio State Medical Association's Committee on Rural Health. To help solve some of the health problems in rural areas, he is working closely with state medical societies, state rural health chairmen, extension services, farm organizations and other civic groups in the formation of community health clinims, councils and local improvement associations.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since April 7, 1950. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ASHTABULA COUNTY
Ernest F. Lindenmayer, Ashtabula

CLARK COUNTY
Greer A. Allen, Springfield

CUYAHOGA COUNTY
Richard P. Bell, Jr., Cleveland
Arthur E. Burns, Cleveland
Charles M. Clark, Cleveland
John J. DeJak, Cleveland
Barry A. Friedman, Cleveland
Herman K. Hellerstein, Cleveland
John A. Hunter, Jr., Cleveland
William M. Jefferies, Cleveland
Felix E. Karpinski, Jr., Cleveland
James S. Kaufman, Cleveland
Howard D. Kohn, Cleveland
David R. Long, Cleveland
Joseph P. Martin, Cleveland
Albert F. Portmann, Cleveland
Thomas P. Rab, Cleveland
Clark T. Randt, Cleveland
Morton Rosenthal, Cleveland
George W. Rowney, Cleveland
Hans J. Rubin, Cleveland
Hyde G. Sample, Jr., Cleveland
John P. Storaasli, Cleveland
Fred R. Tingwald, Cleveland

DARKE COUNTY
Wayne S. Ramsey, Greenville

FRANKLIN COUNTY
Drew J. Arnold, Columbus
Floyd M. Beman, Westerville
Robert S. Darrow, Columbus
Richard L. Fulton, Columbus
George P. Hummel, Columbus
Charles E. Johnston, Columbus
Joseph D. Kiener, Columbus
Paul E. Leithart, Columbus
James W. Long, Columbus
Walter Lowenstein, Columbus
Robert Pickett, Columbus
John P. Riepenhoff, Columbus
Harry M. Sage, Jr., Columbus
John A. Scholl, Columbus
Roy E. Swenson, Worthington
Richard C. Troutman, Columbus
David H. Watkins, Columbus

GUERNSEY COUNTY
Wm. W. Bryant, Senecaville

HAMILTON COUNTY
Frank P. Cleveland, Cincinnati
Forrest V. Cress, Cincinnati
Albert A. Kattus, Jr., Baltimore, Maryland
Harvey C. Knowles, Jr., Cincinnati
Clarence J. Podore, Cincinnati
Helen C. Sharp, Cincinnati
Herman Ulevitch, Cincinnati

HARDIN COUNTY
Robert F. Schultz, Kenton

HARRISON COUNTY
Carl J. Nicosia, Bowerston

HURON COUNTY
Carl R. Swanbeck, Huron

LORAIN COUNTY
Lawrence C. Meredith, Oberlin

LUCAS COUNTY
Jack M. Kenyon, Toledo
Robert D. Kiess, Toledo
Donald C. Wilson, Toledo

MAHONING COUNTY
E. R. McNeal, Youngstown
Jerome B. Stechschulte, Youngstown

MEDINA COUNTY
Wm. G. Halley, Lodi

MIAMI COUNTY
Robert L. Sutton, Tipp City

MONTGOMERY COUNTY
Malachi W. Sloan, II, Dayton

SANDUSKY COUNTY
Carroll D. Miller, Fremont

STARK COUNTY
Theodore J. Dodd, Canton
Clovis A. Watson, Jr., Canton

SUMMIT COUNTY
Reynolds P. Desman, Akron
Joseph A. Masaryk, Barberton
Benjamin Moorstein, Akron
Ernst S. Pawel, Akron

TUSCARAWAS COUNTY
Philip T. Doughten, New Philadelphia



Pollens may invade the air as early as January in California and last through December in Florida.

wherever hay fever may be

and whatever the pollens, a valued measure of symptomatic relief can be expected in most patients with

Trimeton®

(brand of prophenpyridamine)

TRIMETON,® one of the first of the more potent antihistaminic compounds, continues to be, as always, a reliable means of making the hay fever sufferer more comfortable. Because the incidence of side effects is relatively low, it is rarely necessary to discontinue TRIMETON.

Packaging: TRIMETON Tablets (prophenpyridamine) 25 mg. Bottles of 100 and 1000 scored tablets. TRIMETON Maleate Elixir containing 7.5 mg. per teaspoonful is available in bottles of 4 and 16 oz. Patients taking TRIMETON should be informed of the nature of side effects common to all antihistamines.

Schering CORPORATION · BLOOMFIELD, NEW JERSEY

TRIMETON

SCHERING

Washington Roundup . . .

A Review of Developments on Proposed Medical and Health Legislation Before the Congress, With Observations on Other Matters of Interest

WITH an all-important election period approaching a deadline and legislators anxious to wind up the 81st Congress, observations and predictions as these columns are written may indeed be "stale as yesterday's newspaper" by the time *The Journal* reaches its readers.

The following items in brief are given, therefore, not as any final authority, but merely as some observations on happenings as they develop in Washington.

The American Medical Association's Washington office is constantly flashing back to Chicago and to the State Associations throughout the country information on matters that are or can develop into vital issues for the medical profession.

* * *

An imposing group of educational associations now are throwing their support behind legislation to remove the U. S. Office of Education from the Federal Security Agency and establish it as a separate agency. Six organizations, including the National Education Association, have indorsed H. R. 8161, which would turn over Federal education activities to a board and a commissioner to be appointed by the board.

This is the first time this type of legislation has had such wide support from educational groups, some of which in the past have favored a cabinet-rank department of Health, Education and Welfare. This development means important new allies for the medical profession in its opposition to any such grouping of government activities.

* * *

The Brookings Institution's comprehensive survey on the country's health services—doctors, hospitals, prepayment plans, public health facilities and other factors—which began late last summer is reported approximately half completed. At the beginning of the task it was estimated that eight persons would be sufficient for the project. However, 15 full-time workers are now on it.

* * *

Under sponsorship of the Federal Security Agency a Conference on Problems of the Aging will be held in Washington August 13-15. Administrator Oscar Ewing said that invitations are being issued to individuals—not to associations as such. Approximately 1000 persons from the government, industry, education, labor, and the professions are expected. Mr. Ewing said that government officials had no preconceived ideas about future action but were scheduling the conference merely in the hope that out of the discussions will develop a more coordinated and fruitful program. Washington observers report, however, that an F. S. A. committee has been working in this field for two years and reports as follows: "One principle suggests itself at the start, namely — the Federal government should establish a clearing house for studies of the problems for the aging population, with broad authority for research and promotion in this field."

* * *

The Veterans Administration has ruled that any eligible veteran who starts his pre-medical course by July 25, 1951, but is delayed in entering medical schools by factors beyond his control, will be considered eligible for medical school benefits whenever he can gain admission. This ruling is expected to solve the problem which prompted introduction of H. R. 7235 which would by law extend the educational time limit beyond the July 25, 1951, deadline.

* * *

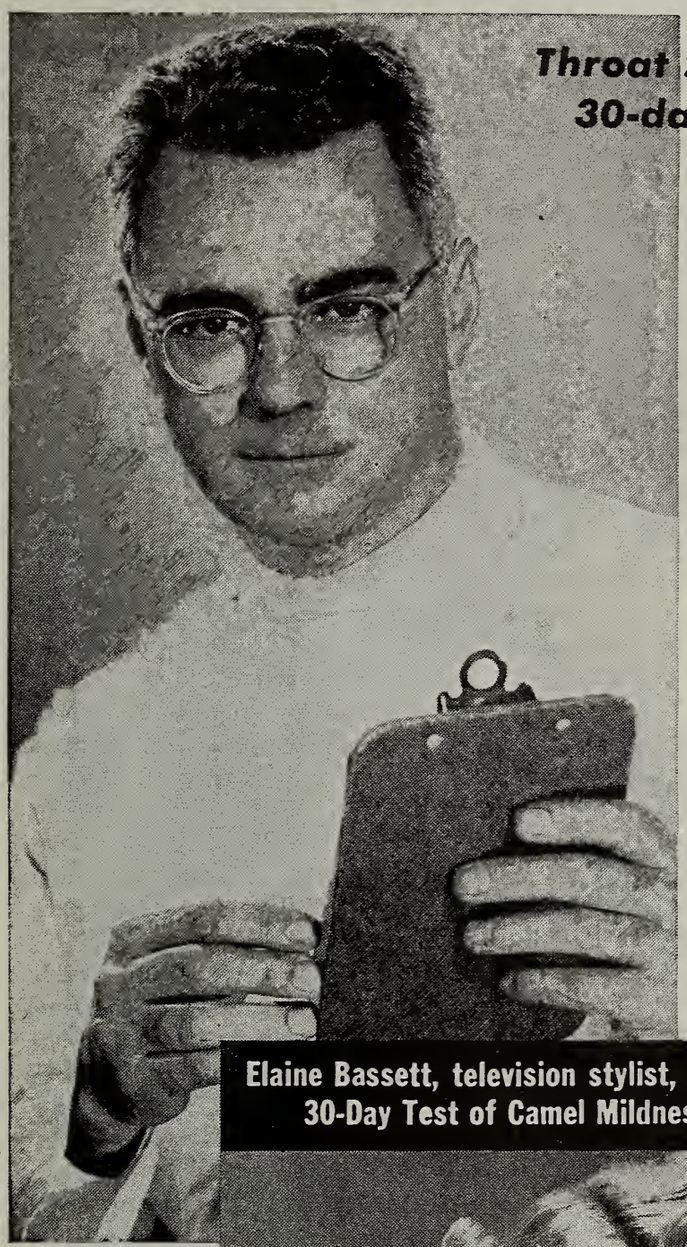
With the Citizens Committee on the Hoover Report coming out in opposition to the President's Reorganization Plan No. 27 to create a Department of Health, Education and Welfare, another strong force is in the corner with the medical profession. Senator Taft has declared himself in opposition as reported in a special article on page 713 of this issue.

* * *

A bill that would provide for Federal reinsurance of voluntary, non-profit medical and hospital insurance associations against catastrophic illnesses has been introduced in the House by Representative Charles A. Wolverton (R.-N.J.). In general the bill follows the suggestions advanced by Harold Stassen. Under the proposed bill (H. R. 8746) a Federal corporation would assume 66-2/3 per cent of all risks in excess of $1,000 per subscriber per year. Among limitations is a specification that the individual would be required to pay a token share of all costs.

* * *

A pamphlet on "Better Medical Care That You Can Afford," being distributed by the Democratic National Committee, is out-and-out propaganda for President Truman's health plan. All the opposition that has been mustered against the proposed national compulsory insur-



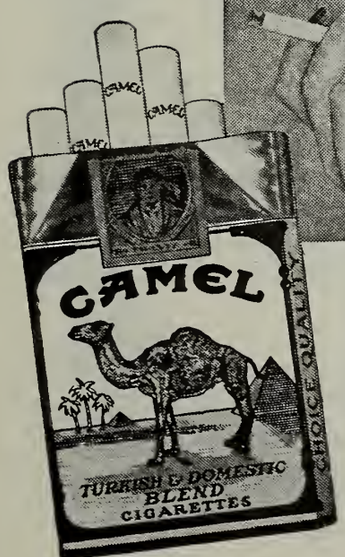
Throat Specialists report on 30-day test of Camel smokers:

"Not one single case of throat irritation due to smoking Camels!"

Yes, these were the findings of throat specialists after a total of 2,470 weekly examinations of the throats of hundreds of men and women who smoked Camels—and only Camels—for 30 consecutive days.

Elaine Bassett, television stylist, is one of hundreds, coast to coast, who made the 30-Day Test of Camel Mildness under the observation of throat specialists.





R. J. Reynolds Tobacco Co., Winston-Salem, N. C.

ACCORDING TO A NATIONWIDE SURVEY:

More Doctors Smoke Camels

THAN ANY OTHER CIGARETTE

Yes, doctors smoke for pleasure, too! In a nationwide survey, three independent research organizations asked 113,597 doctors what cigarette they smoked. The brand named most was Camel.

ance program is dismissed in these two sentences: "Why do some people oppose it? Either because of self-interest or because they don't understand it."

In typical propaganda fashion, the pamphlet glides smoothly over many questionable statements. It states "you would choose your own doctor" and "the doctor would choose his patients," but it does not explain how that choice would be exercised in areas where there are shortages of doctors and few patients. It states that "a worker would pay 1½ per cent of his earnings under $400 per month." It does not explain that costs would mount as the program developed, nor that the Treasury Department would have to make up any deficit out of general taxes.

* * *

The Armed Forces Epidemiology Board in an official report maintains that the anti-histamines are useless against true cases of comomn colds. Persons suffering from allergies were eliminated from the group tested. The report does not go into the effectiveness of anti-histamines on allergic persons who might believe they are suffering from colds.

* * *

The Army announced that all reserves planning on summer field training must have their immunization brought up to date. Similar announcements were expected from the Navy and Air Force. Earlier plans to have all members of the reserve and national guard check up on their shots were abandoned at least temporarily, apparently because such a move might heighten war jitters.

* * *

Dr. Leonard A. Scheele, Surgeon General of the U. S. Public Health Service, upon his return in mid-June from the World Health Assembly meeting in Geneva, urged that the United States raise its contribution to the World Health Organization to $2,500,000. Dr. Scheele who has carried on health projects in 76 countries said that almost half the people of the world suffer from preventable disease. He contends that such illness contributes to the type of sub-marginal society where communist propaganda can easily take root. The two-and-a-half millions is the amount set by W. H. O. despite the fact that Congress set the ceiling at $1,910,000.

* * *

The Department of Agriculture (Federal) has started a wholesale diabetes detection survey of its 11,000 employees. If the test shows possible diabetes, the employee is sent to a private physician.

* * *

Announcement has been made that the Defense Department has waived the requirement that Medical Corps reserve officers must accumulate 12 points before July 1 of this year in order to retain their active status. The announcement is not a statement of policy, but is intended as an interim measure for those physicians who have not had time for reserve activities during the past year.

Ohio Academy of General Practice Elects Officers at Annual Meet

Dr. Gordon Erbaugh, of Dayton, was named president-elect of the Ohio Academy of General Practice at its annual meeting in Cleveland, May 16. He will be installed as president at the 1951 annual meeting.

Dr. Earl D. McCallister, Columbus, was re-elected secretary-treasurer.

Dr. Roscoe M. Knoble, Sandusky, was installed as president for the present year, succeeding Dr. Emery G. Kyle, of Newton Falls.

District members elected to the Board of Directors are: Dr. Wallace C. Madden, Dayton, District Number Two; Dr. Wayland B. Recker, Leipsic, District Number Four; Dr. Earl W. Burgner, Akron, District Number Six; Dr. Lawrence H. Miller, Granville, District Number Eight; and Dr. Perry B. Wiltberger, Columbus, District Number Ten, reelected.

National delegates to the Annual Scientific Assembly of the American Academy of General Practice to be held in San Francisco in 1951 are Dr. Recker and Dr. Howard R. Mitchell, Columbus. Alternates are Dr. Earl D. Van Horn, Cincinnati, and Dr. Thomas Shehan, Cleveland.

Dr. Paul A. Davis, Akron, first national president of the American Academy of General Practice, spoke to members relative to the Blue Cross prepaid hospital care plan and informed members of some of the serious conditions which have developed which are of vital interest to all physicians.

Dr. George F. Lull, Chicago, secretary and general manager of the American Medical Association, spoke briefly about the setup of the A. M. A. Mr. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, spoke briefly to the Academy.

The annual business meeting was attended by 204 members out of a state membership of 834 members, the secretary reported. The secretary further reported that the Academy's booth on the floor of the exhibit hall was a great success despite the fact that the railroad strike stopped shipment of a great deal of the material from the national office.

The Army announced that a new type of scrub typhus vaccine has been sent to Malaya for testing by an Army Medical Department team. Tests will be carried on to determine the effectiveness of the vaccine against typhoid fever as well as scrub typhus.



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*PB abbreviated designation for phenobarbital.

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Ohio Hospitals . . .

A. M. A. Annual Survey Shows That Utilization of Services in Ohio And Other Institutions Increased Considerably for the Year 1949

A NEW high in the utilization of hospital service in the United States was reached during 1949, according to the annual presentation of hospital data by the Council on Medical Education and Hospitals of the A. M. A., reported in *The Journal of the A. M. A.*, May 6.

Patients admitted to hospitals registered by the A. M. A., reached a total of 16,659,973, an increase of 237,199 over the previous year. The bed capacity of 1,439,030 showed an increase of 15,510, while the average daily census of 1,224,951 was 6,797 more than were recorded in 1948.

In Ohio there was a similar increase in utilization of hospital services. Although the total number of hospitals remained the same, there was an increase of 566 in the number of beds, an increase of 53 bassinets, 15,427 more patients admitted and an increase in the average census of 766.

BIRTHS

In the last 20 years the number of hospital births in the United States has increased from 621,867 to 2,820,791. The two million mark was first exceeded in 1946, while the following year set an all-time record of 2,837,139. The 1949 total is only 16,348 less than the record and exceeds the 1948 total by 26,510. In Ohio there were 171,533 births in hospitals in 1949.

OHIO HOSPITALS

The report shows the following hospital facities in Ohio:

Federal Hospitals 6; beds 5,073; patients admitted 19,965; average census 4,408.

State Hospitals 27; beds 33,216; bassinets 36; patients admitted 28,560; average census 31,675.

County Hospitals 27; beds 4,139; bassinets 124; patients admitted 22,599; average census 3,510.

City Hospitals 18; beds 3,522; bassinets 360; patients admitted 69,845; average census 2,844.

City-County Hospitals 1; beds 72; bassinets 22; patients admitted 3,495; average census 70.

Total Governmental Hospitals (a summary of the preceding) 79; beds 46,052; bassinets 542; patients admitted 144,464; average census 42,507.

Church Related Hospitals (nonprofit) 47; beds 8,408; bassinets 1,449; patients admitted 299,694; average census 6,965.

Nonprofit Association Hospitals 97; beds 10,718; bassinets 1,951; patients admitted 369,192; average census 8,464.

Total Nonprofit (summary of preceding two classifications) 144; beds 19,126; bassinets 3,400; patients admitted 668,886; average census 15,429.

Individual and Partnership Hospitals 9; beds 350; bassinets 14; patients admitted 1,211; average census 260.

Corporation Hospitals (profit unrestricted) 8; beds 551; bassinets 18; patients admitted 5,732; average census 465.

Total Proprietary (summary of the preceding two classifications) 17; beds 901; bassinets 32; patients admitted 6,943; average census 725.

Total Nongovernmental (summary of the preceding nongovernmental) 161; beds 20,027; bassinets 3,432; patients admitted 675,829; average census 16,154.

Grand Total of all registered hospitals in Ohio (summary of the preceding) 240; beds 66,079; bassinets 3,974; patients admitted 820,-293; average census 58,661.

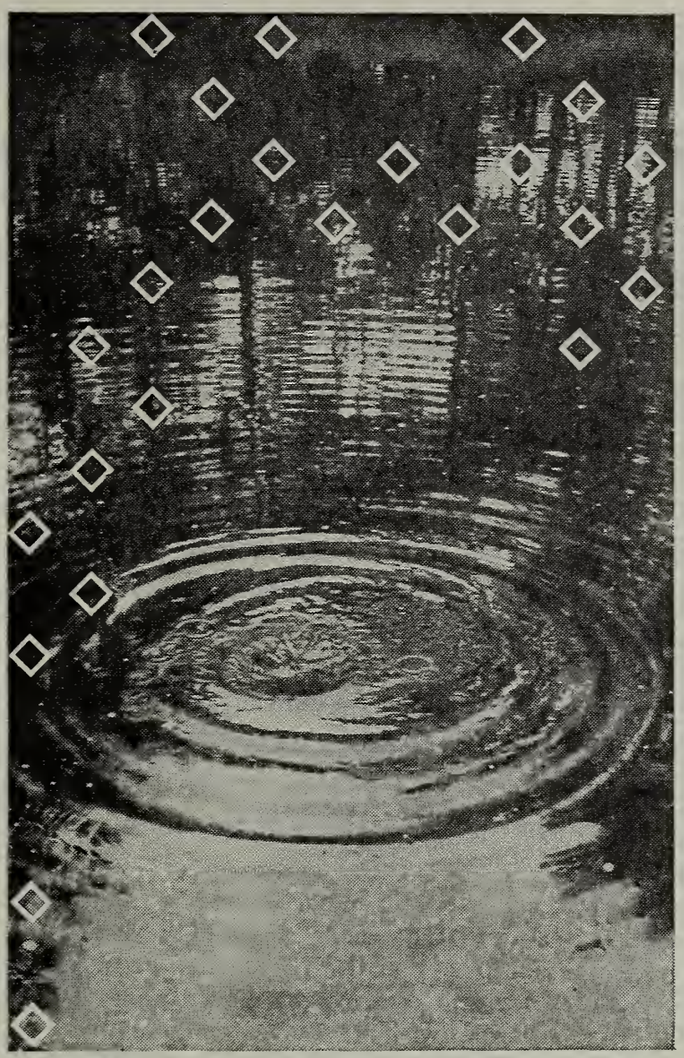
TYPE OF SERVICE

Following are the number of hospitals in Ohio and number of beds according to type of service offered: General, 148 with 24,069 beds; nervous and mental, 28 with 34,298 beds; tuberculosis, 23 with 3,891 beds; maternity, 9 with 212 beds; industrial, 1 with 18 beds; children's, 3 with 531 beds; orthopedic, 3 with 160 beds; convalescent and rest, 7 with 327 beds; hospital departments of institutions, 11 with 962 beds; all other hospitals, 6 with 1,612 beds.

NURSING PERSONNEL

The A. M. A. report shows the following statistics in regard to professional nursing personnel and schools of nursing education in Ohio: Student nurses, 5,602; accredited schools of nursing, 61; schools offering affiliating courses only, 10 with 679 students; administrative nursing personnel, 372; full-time instructors, 320; supervisors and assistant supervisors, 954; head nurses and assistant head nurses, 1,453; general duty nurses full-time, 5,164; general duty nurses part-time 1,447; nurses not classified, 177; total graduate nurses, 9,887; private duty nurses, 1,659.

The report further shows the following information on auxiliary nursing personnel and school of practical. nursing; Schools of practical nursing, 5; practical nurse students, 56; practical nurses employed, 781; attendants, 5,183; nurses' aides, 4,784; ward maids, 1,092; orderlies, 964.



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PRESIDENT

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

KNOCK-OUT DRIVE PLANNED BY THE A. M. A. THROUGH ADVERTISING PROGRAM IN FALL

ELSEWHERE in this issue will be found a news article regarding a nation-wide advertising program which will be launched in the Fall by the American Medical Association as a part of its National Education Campaign.

The A. M. A. Board of Trustees will win the commendation of many for continuing its policy of taking the initiative in the matter of telling the people what the medical profession stands for, how voluntary methods can solve the medical and health problems of the people, and about the dangers of government control of medicine as well as all professions and business.

As the advertising campaign progresses, the cooperation and help of state and local medical societies, individual physicians, allied professional groups and laymen will be needed to make the program really click. Therefore, these groups and individuals should be ready to pitch in when the word goes out to them.

Following is a statement issued by Whitaker & Baxter, public relations agency which is handling details for the entire National Education Campaign, emphasizing the major features of the advertising program and its why's and wherefore's:

"As publicly announced on May 29, the Board of Trustees and Campaign Coordinating Committee decided unanimously to bring the efforts of the National Education Campaign to a climax in October, with an advertising program designed to crystallize public sentiment on the issue of Voluntary versus Compulsory Health Insurance.

"We have been asked by the Board and the Committee to advise you of the main considerations determining this course. Here are the major factors involved:

"In order to relieve the medical profession of any necessity for a continuing, exhaustive campaign for survival, it is imperative to find a way to bring the issue of Government-controlled medicine to a public conclusion.

"The most desirable action possible, naturally, would be a vote in Congress—and that conclusion we are thoroughly prepared for, and would welcome.

"However, the issue will not be permitted by its sponsors to emerge in this Congress, and we are forced to find other means to solidify medicine's position.

"Medicine, in its National campaign, has won the support of the greatest cross-section of public sentiment ever amassed on a controversial public issue in this country. Medicine and its allies have proved to millions of people and to thousands of publicly responsible organizations that the problems of medical service, care and cost can be solved under the Voluntary system, without Federal controls.

"The need now is to crystallize that general public sentiment into concrete public certainty.

"The need is to prove that if a General Election were called on the issue of Compulsory Health Insurance, the people would vote "No!"

"The need is to show that Compulsory Health Insurance is discredited in the eyes of most Americans, and that the benefits of Voluntary Health Insurance are more firmly established day by day.

"The need is to build and solidify the confidence of the public in the medical profession.

"The need is to build the confidence of doctors in their own leadership, local, State and National—and in their own ability to solve their problems. Doctors and their allies have done a spectacular job of turning the tide which would have destroyed the profession. In directing the National Campaign—whose success 18 months ago looked pretty disheartening—the A. M. A. Board of Trustees and Coordinating Committee have earned the sincere respect of leaders in business and industry and other professions, for their forthright battle against the threat of socialism. On this basis, medicine's crusade has won recognition as a service to the entire Nation.

"For its effect on future political events affecting the profession, the respect and esteem medicine has won needs to be pointed out to the Nation at large. It needs to be crystallized into a firm foundation of strength, which medicine

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well may need in the future. **It needs to be capitalized at its height—toward the nullification of the efforts of those who will continue to try to discredit medicine.**

"All these things and many more, the advertising program is geared to accomplish. The program above all else will strive constructively to solidify the position and build the prestige of the profession generally—and **since the finality of a Congressional vote is denied medicine at this time—it is our intention to end this campaign with the conclusiveness of the people's mandate we know we have.**

We are aware this is a big order. We shall do our utmost to fulfill it. We are aware that irrespective of what is done, the program will have some critics. The only way to avoid criticism is to do nothing. And your Committee and Board—fortunately for medicine—do not advocate the dubious "safety" of inaction."

EXCELLENT HUNCHES FOR AUXILIARY PROGRAMS

Occasionally, a newly organized Woman's Auxiliary to a County Medical Society has found itself a bit puzzled as to just what kind of a year's program it should provide for its members—just what its responsibilities and activities should be.

New auxiliaries organized in Ohio during the next 12 months—in fact, auxiliaries now in existence—will be in a fortunate position. A program committee of the State Auxiliary, under the chairmanship of Mrs. E. B. Gillette, Toledo, a former president of the state organization, has just issued a bulletin to all local auxiliaries in which have been incorporated some excellent suggestions for local auxiliary activities and programs.

Please note that the bulletin, the text of which follows, points up how the auxiliary can assist and cooperate with the local medical society (in fact, some of the ideas offered would make corking good programs for most of the County Medical Societies):

"A Program Chairman should be carefully selected in each County. She must work closely with the President and the Board. Her ideas for Programs may overlap those of other Committees, therefore, she must consult and cooperate with other Auxiliary Chairmen.

"The plan for the Year's Program must be approved by the Auxiliary Board and the advisor from the County Medical Society. It would be well to ask the advisor for suggestions before the program is completed.

"The component Auxiliaries vary in membership from 7 to over 400. No set pattern can be applied, but we hope that each County Chairman may find the following suggestions helpful in planning their Program for 1950 and 1951.

"1. Plan program early. Select some goal to be achieved. Decide length of time for meeting. Start and close meetings promptly.

"2. Form Speakers' Bureau. List available speakers. Use these speakers for Auxiliary programs and make them available to other groups.

"3. Encourage younger members and new members to participate in program, or its responsibilities if possible.

"4. Know the aims of the A. M. A. Study its history, functions, work of various departments, twelve (12) point plan, its contribution to mankind, etc.

"5. Arrange program on pre-payment medical care and hospital plans. Speakers—representative of local or state plan or local physician.

"6. Study Legislation, local, state and national—which affects health and medicine. Have report on legislation at each meeting. Qualified Speakers: Members of Medical Society, legal advisors or counsel.

"7. Public Health Meetings. Speaker—health commissioner, mayor or other executives. Study local and state health facilities available, school and rural problems. Invite other Women's Club members to this meeting. This means good public relations.

"8. Program on Geriatrics: Speaker from local nursing home, aid to the aged department, county home. Discuss care and facilities.

"9. Nurse Recruitment: Tea. Suggest help to nursing schools, etc. Speaker: Hospital superintendent, staff physician, County Society President or others interested.

"10. Study Groups (these are apart from program): Might report at meetings. Also participants in health campaigns such as cancer drive, polio, etc. Bring reports.

"11. Leave time on program to cooperate with Medical Society in new projects. Be informed on medicine's aims. Tell others.

"12. All work and no play is not a good program. Luncheon or tea meetings attract members. A dinner dance given with the Medical Society has proven popular.

"In making your program, consider home needs first. Use as many of the above suggestions as you wish. If we can be helpful at any time, communicate with us.

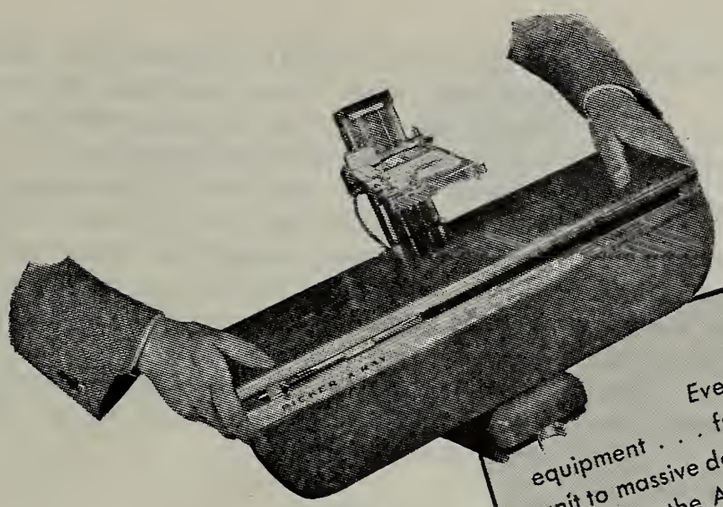
"Let us work together so that the Women's Auxiliary may be a credit to its parent."

CHECK YOUR WORKMEN'S COMPENSATION FILES OFTEN

Physicians who do an appreciable amount of industrial practice should check their files routinely every six months for pending or incomplete Workmen Compensation claims. Delay in payment may be due to one or more of several causes. Perhaps the employer has not filed the claim. He may not have coverage. Information may be missing or incomplete from the employer, employee, or attending physician. Signatures may have been omitted. If an X-ray was taken, the film may not have been filed, and payment of the bill of attending physician for treatment therefore delayed. The employer may be contesting the compensability of the claim.

Whatever may be the reason for the delay in paying your bill, you are more likely to get it straightened out by initiating the inquiry early while the claim is still alive than by

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waiting for a year or more (as some physicians do).

After you've made your semi-annual inventory of industrial cases, make a list of those for which payment of your fee bill has been delayed six months or more. On such claims, first call the employer for the number. If he can't furnish it, then he hasn't filed the claim with the Industrial Commission. When a claim is received by the Commission, the employer is immediately notified of its number. Your 'phone call may release the claim blank from that pigeon-hole.

Your list of "pending" claims should include the claim number, if available; name of employer; name of employee, date of injury.

Send the list to C. C. Grubbs, assistant supervisor, Claims Section, State Industrial Commission, State Office Building, Columbus. You'll get a prompt explanation of what is holding up payment of your bill. If you prefer, send the list to the Headquarters Office of the State Medical Association, and a member of the staff will follow through.

Of course, some of the delays in payment of medical bills are the fault of the Industrial Commission's office. It is the responsibility of that office to see that claims are properly and promptly adjudicated and that claimants and physicians are compensated in accordance with the law and the regulations. At times, the system used in handling approximately 25,000 claims each month short circuits; delays occur or fee bills are misplaced. However, about 90 per cent of the claims and bills go through for payment within a reasonable time. Efforts of the Commission to straighten out cases which have run into difficulty are limited by the volume of the work and the perennial shortage of personnel.

You can help the Commission's staff by advising it promptly and periodically of cases in which payment to you is delayed. Periodic examination of your files should be made so a check can be made by the Commission and the difficulty straightened out.

ACCIDENTAL DEATH RATE FOR 1949 REACHES ALL-TIME LOW

It seems that we Americans lived less dangerously during 1949 than in former years, according to reports of accidental deaths. Metropolitan Life reported that for 1949 the estimated toll from accidents was 92,000 lives, a marked decline from the 98,000 of 1948.

In fact, the 1949 figures will be the lowest for any year of the past decade, and in relation to population, mortality from accidents will be the lowest on record for the Nation.

For the benefit of anyone who wishes to philosophize on the recklessness of the present generation, we might note that again accidents in the home (33,000) accounted for more lives than any other class. Accidents in the home usually are caused by lack of forethought or failure to exercise ordinary precaution.

Motor vehicle fatalities fell somewhat below the total of 32,000 recorded in 1948. In relation to travel mileage, deaths from motor vehicle accidents, when all statistics are in, probably will be the lowest ever experienced. Occupational accidents also showed a sharp decline.

Undoubtedy the many safety education programs are having their effect on the lowering of accidental deaths.

LIVES OF GREAT MEN REMIND US

Many newspaper clippings have been coming into the office of *The Journal* recently in connection with awarding of 50-Year Pins. Many of these contain biographical sketches or reports of reminiscences of these oldsters in the profession.

One characteristic which perhaps predominates in these sketches is that doctors, in spite of their busy professional lives, usually are civic minded to a marked degree. It is an exceptional biography which does not report the doctor as having interests in some community enterprise—the high school football team, the Elks Club, the American Legion, board of education, public health projects, the chamber of commerce, some church, or any other of a hundred activities which help the community to be a community.

A study of just how much time doctors contribute to community affairs in addition to their strictly professional work would be interesting. Without question it would be high.

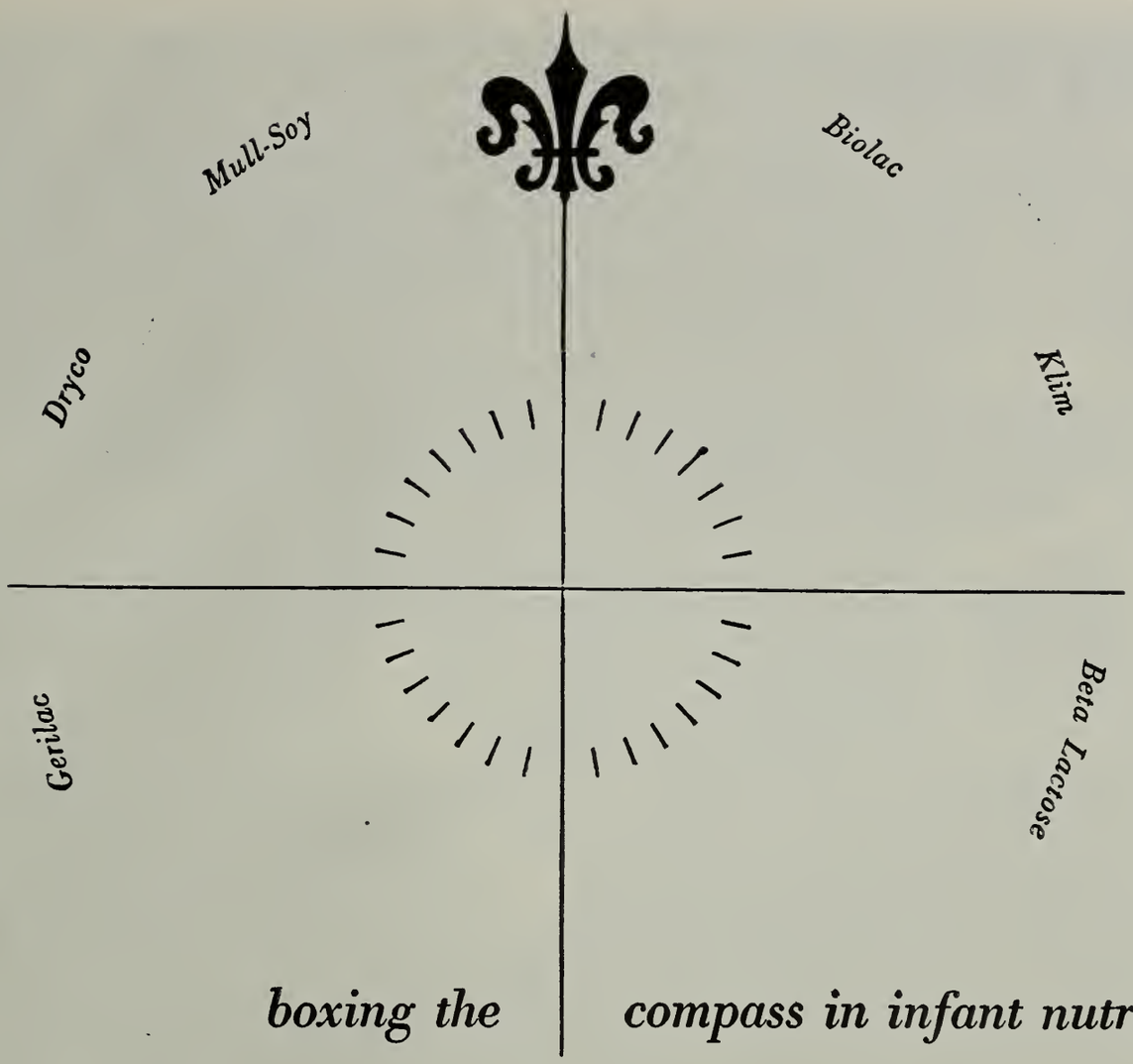
The doctor has his circle of patients who know him intimately and who benefit most from his store of ability. Taking part in these other activities helps the doctor to widen his field of influence and to make more friends for himself and for his colleagues in the medical profession.

IT WOULDN'T BE FREE HERE, EITHER

Low-income Britons are beginning to discover that the "welfare state" isn't free after all, the *U. S. News and World Report* observes.

It points out that actually, low-income taxpayers (80 per cent of Britain's families whose incomes are under $1,400 a year) pay more in taxes than they get back in welfare benefits. They pay, on the average, about $9.50 in taxes per family per week and they get back in welfare benefits, about $8.00 per family per week. Let those who think the proposal for a "give away" state in the U. S. A. is free, take notice.

Which brings to mind the following definition from some wit: **"Federal aid: A system of making money taken from the people look like a gift when handed back."**



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Do You Know? . . .

Roger C. Crafts, Ph. D., is the new head of the department of anatomy in the University of Cincinnati College of Medicine. He has been associate professor of anatomy at Boston University School of Medicine. During the war he was with the Office of Naval Research.

* * *

"Bronchiectasis and Tuberculous Bronchitis," was the subject discussed by Dr. Maurice G. Buckles, Columbus, at the annual meeting of the American Academy of Tuberculosis Physicians, June 24, in San Francisco.

* * *

Premium income of the accident and health insurance industry was more than $1,171,600,000 in 1949, according to a preliminary estimate of the Health and Accident Underwriters Conference. This total is 16 per cent higher than in 1948. The premium total in 1933 was approximately $175,000,000.

* * *

The June 10 issue of the *Journal of the A. M. A.* contains a complete report on postgraduate courses for practicing physicians, compiled by the Council on Medical Education and Hospitals. The listing is by specialty and covers courses at medical schools for the period July 1, 1950 - Jan. 15, 1951.

* * *

A resolution opposing compulsory health insurance was tabled at the recent biennial convention of the American Nurses' Association. The Association's new president is Mrs. Elizabeth K. Porter, assistant director and professor of nursing, Western Reserve University, Cleveland.

* * *

Dr. Fowler B. Roberts, Akron, is the new president-elect of the Ohio Orthopedic Society.

* * *

The Ohio State Medical Association's scholarship for rural medical students was explained in a recent broadcast over WRFD, Worthington, the Ohio Farm Bureau radio station, by Hart F. Page, secretary of the Committee on Rural Health of the Association.

* * *

Over 100 officers of local women's organizations were guests of the Woman's Auxiliary of the Lima and Allen County Academy of Medicine at an afternoon meeting and tea at Lima, April 27. George H. Saville, Director of Public Relations, Ohio State Medical Association, spoke on the subject, "Uncle Sam, M. D."

* * *

Unitarian Service, Inc., has named Dr. John H. Dingle, Cleveland, professor of preventive medicine, Western Reserve University School of Medicine, a member of a medical mission to go to Japan this summer to teach the latest medical techniques to doctors whose scientific progress was arrested during the war.

* * *

Dr. Richard L. Meiling, chief of medical service, Office of Defense, has been awarded the honorary degree of Doctor of Science by his Alma Mater, Wittenberg College, Springfield.

* * *

Two Ohio physicians are members of the Scientific Program committee for the 1951 meeting of The American Academy of General Practice in San Francisco. They are Dr. Tom E. Rardin, Columbus, vice-chairman, and Dr. Joseph C. Lindner, Cincinnati.

* * *

A committee of the Medical College of Virginia recently interviewed each of its 92 senior medical students to aid them in the choice of an internship. It was found that 53.26 per cent of the students indicated an intention to enter general practice.

* * *

Dr. Richard L. Meiling, Columbus physician, now director of medical services, Office of the Secretary of Defense, was named official adviser to the U. S. Delegation at the World Health Organization which met in Geneva, Switzerland, in May. While in Europe Dr. Meiling visited military medical installations in the occupied areas and the medical facilities of the U. S. Air Force in England.

* * *

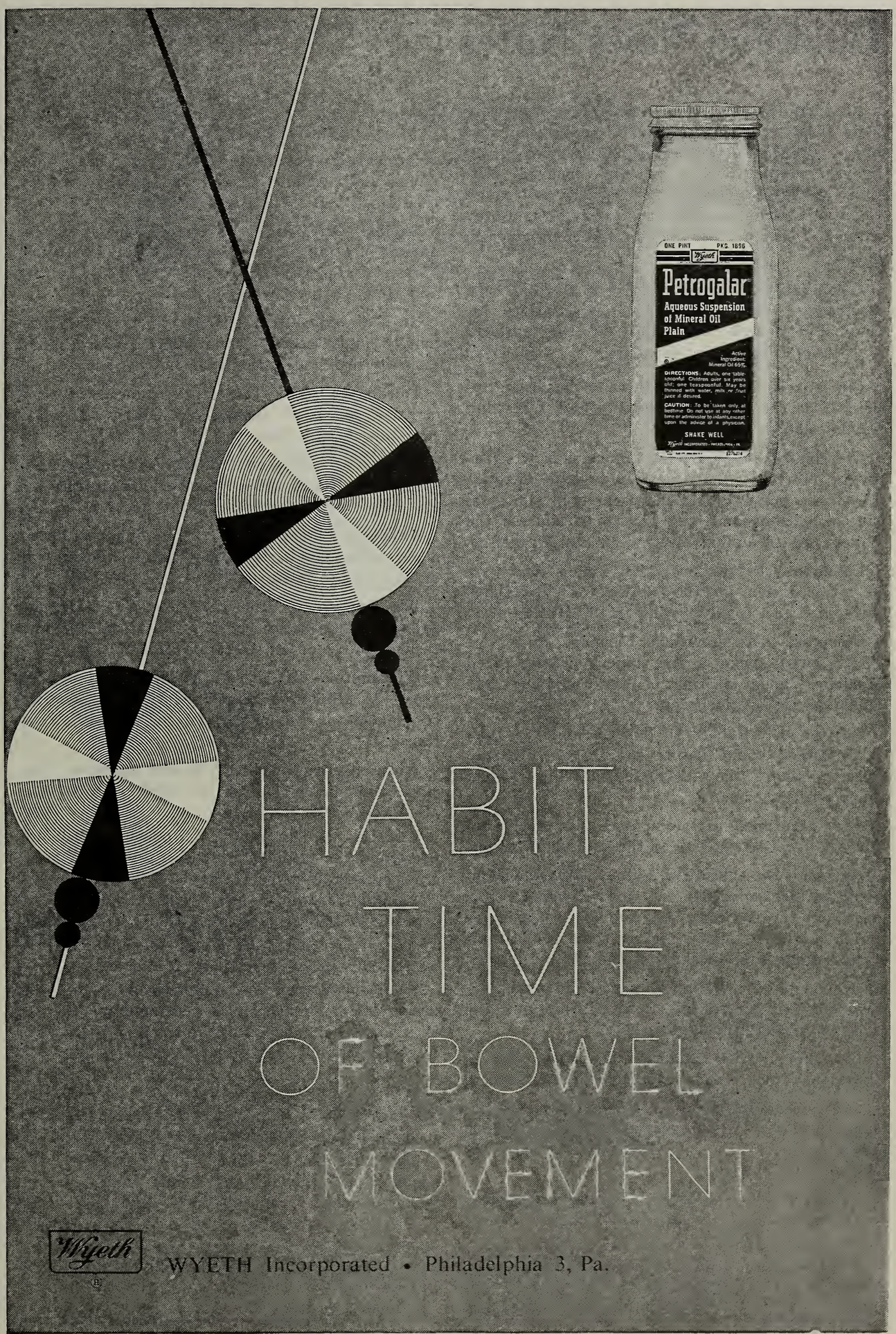
Dr. Allan C. Barnes, Columbus, spoke on "Use of Radioactive Cobalt in Treatment of Carcinoma of Cervix," at the meeting of the American Gynecological Society, held at White Sulphur Springs, W. Va., May 11-13.

* * *

Dr. F. F. Keiser has retired as superintendent of Columbus State School, after serving at the institution for 43 years. His successor is Dr. Roger Gove, former director of the Upper Miami Valley Child Guidance Center, Piqua.

* * *

The scientific exhibit on "Translumbar Arteriography" by Drs. Parke G. Smith, Thomas W. Rush and Arthur T. Evans, Cincinnati, which was awarded first prize at the annual Meeting of the Ohio State Medical Association in Cleveland, May 15 - 18, also won the top award at the meeting of the American Urological Association, May 29 - June 1, at Washington, D. C.


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Buckeye News Notes . . .

Chardon—Dr. and Mrs. Walter C. Corey were honored at a banquet given "in recognition and appreciation of untiring public service given by the couple over a quarter century." Dr. Corey recently retired after 25 years as Geauga County health commissioner and Mrs. Corey after 25 years as secretary of the county health board.

Cincinnati—Dr. Eugene B. Ferris, Jr., has been elected president of the American Society for Clinical Research and editor of the society's *Journal of Clinical Investigation.*

Cincinnati—Dr. Braxton F. Cann has been appointed to the Cincinnati Boxing and Wrestling Commission.

Cleveland—Dr. Henry A. Zimmerman won the award offered by the American College of Chest Physicians for outstanding research in abnormal lung conditions and was invited to address the College at its annual meeting in San Francisco.

Columbus—Dr. Robert E. S. Young took part in a discussion on the subject of "Socialized Medicine" at a town meeting in the Hilltop area.

Columbus—Dr. Jonathan Forman, Editor of *The Journal*, spoke on the subject of "Socialized Medicine" at a meeting of the Columbus Life Underwriters' Association.

Dayton—Dr. Robert E. Boswell and Dr. John T. Bickmore spoke before the Dayton Hearing Society, where they discussed hearing defects and their remedies.

East Liverpool—Dr. John A. Fraser spoke before the local Lions Club on the subject of cancer.

Grafton—Dr. Clifford S. Palmer, Massillon, immediate past-governor of the Kiwanis Club, spoke on the subject, "Aggressive Citizenship—Safeguard of Freedom," before some 200 Kiwanians representing 15 clubs of the Sixth Division.

Greenfield—Dr. Phillip T. Knies, Columbus, addressed the Greenfield Rotary Club on the subject, "Socialized Medicine."

Greenfield—Dr. J. Martin Byers was elected president of the Highland County Health Council.

Jefferson—Dr. Alfred P. Lindenmayer, of Ashtabula, is the new Ashtabula County Health Commissioner. He succeeded Dr. Thomas E. Patton, of Conneaut.

Lancaster—Dr. Wilford D. Nusbaum was general chairman of the Lancaster Fairfield County Sesquicentennial Celebration, June 4-11.

Mentor—Dr. Shelby G. Gamble, Cleveland, spoke at the annual banquet of the Lake County Chapter, National Foundation for Infantile Paralysis, on the subject, "Interesting Sidelights of Infantile Paralysis."

Painesville—Dr. John W. Davis has been named Lake County health commissioner to succeed Dr. W. H. Willis who resigned.

Shelby—Dr. Dwight M. Palmer spoke at the annual meeting of the Women's Guild of Shelby Memorial Hospital on the subject, "Your Nerves and How To Live With Them."

St. Clairsville—Dr. J. B. Martin is acting Belmont County health commissioner. Dr. Homer S. West resigned as commissioner recently.

Toledo—Dr. Max T. Schnitker discussed "Socialized Medicine" before the Mercy Hospital Alumnae Association.

Toledo—Dr. Roscoe J. Kennedy, Cleveland, spoke on "Retrobulbar Neuritis" before the local Eye, Ear, Nose and Throat Society.

Wapakoneta—Dr. Esta C. Yingling, of Lima, spoke before the local Rotary Club on the subject of "Socialized Medicine."

Washington C. H.—Dr. Byers W. Shaw has opened his practice here. He formerly was resident surgeon at Lakeside Hospital.

Wilmington—Dr. Reyburn McClellan, Xenia, spoke on "Hospital Management" at a meeting of the Clinton County Registered Nurses Association.

Wooster—Dr. Lincoln L. Moore spoke on "Socialized Medicine" before the adult class of the Methodist Church.

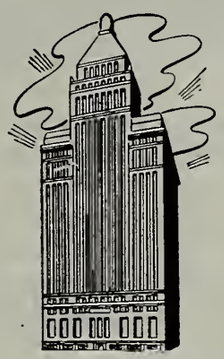
Wooster—Dr. Charles L. Hudson, Cleveland, presented the medical profession's point of view on Socialized Medicine before the Wayne County Community Forum.

Wooster—Dr. Ebert E. Judd addressed the Wooster Branch of the Minute Women of Ohio on the subject of "Socialized Medicine."

Wooster—Wayne and Medina Counties will be under one health commissioner starting July 1. The boards announced appointment of Dr. Earl E. Kleinschmidt as health commissioner. He comes to Ohio from Oak Park, Ill., with 11 years of public health experience. The district includes the Wooster board which has long been combined with the Wayne district.

Youngstown—Dr. John J. McDonough presented the medical profession's viewpoint on national health proposals in a panel discussion before the Youngstown Business and Professional Women's Club.

Zanesville—Dr. Margaret O'Neal, Muskingum County health commissioner, addressed the Parkinson P.-T. A.



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In Memoriam . . .

Daniel R. Barr, M. D., Grand Rapids, Ohio; Toledo Medical College, 1911; aged 64; died May 24; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Barr began his practice in Grand Rapids upon completion of his medical education. From 1915 until 1932 he was medical director of research for the Taylor Instrument Co., after which he resumed his practice in Grand Rapids. He is credited with valuable research in connection with the iron lung and other medical equipment. In addition to his professional work he was active in civic and fraternal affairs. He was a member of the Presbyterian Church, the Exchange Club and several Masonic orders. He was chairman of the Wood County Park Board, a member of the board of directors of the Wood County Red Cross and served on the executive committee of the Wood County Democratic Committee. During World War I, he served overseas with the Red Cross. His widow survives.

Richard A. Brown, M. D., Plain City; Starling Medical College, Columbus, 1896; aged 77; died May 27; former member of the Ohio State Medical Association and the American Medical Association through 1939. Dr. Brown was a trustee of the Mercy Hospital, Columbus, with which he had been affiliated since 1917. He was a member of the Masonic Lodge. Surviving are his widow, two sisters and a brother.

William F. Emery, M. D., Ashland; Western Reserve University School of Medicine, 1897; aged 78; died May 20; member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1948; president of the Ashland County Medical Society, 1932, and delegate of that Society, 1919, 1924, 1925 and 1929. Dr. Emery had practiced medicine in Ashland County for 53 years. Recently he was awarded the 50-Year Pin and Certificate of the Ohio State Medical Association. In additon to his professional services, he was active in other phases of community activities; was a member of the Odd Fellows, a past-president of Rotary Club and a member of the Lutheran Church. He is survived by a son, Dr. George M. Emery, also of Ashland.

John P. Farson, M. D., Columbus; Ohio Medical University, Columbus, 1907; aged 67; died May 30; member of the Ohio State Medical Association and the American Medical Association. Dr. Farson had practiced medicine in Columbus for approximately 20 years before retiring about eight years ago. Before coming to Columbus, he had practiced in Parkersburg, W. Va. He was on the staffs of Mt. Carmel and Grant Hospitals and for more than 20 years attended children at St. Ann's Hospital. He also was an instructor in pediatrics at the Ohio State University College of Medicine. A veteran of World War I, he was a member of the American Legion; and the Veterans of Foreign Wars; he was a member also of the Presbyterian Church and the Rotary Club. Surviving are his widow; his stepmother, two brothers and five sisters.

Robert Miller Fulwider, M. D., Hot Springs, New Mexico; Ohio State University College of Medicine, 1912; aged 63; died May 4; formerly a member of the Ohio State Medical Association and listed in the A. M. A. directory as a member of the Colorado State Medical Society and a Fellow of the American Medical Association. Dr. Fulwider practiced in Zanesfield before World War I.

Albert F. Green, M. D., Cleveland Heights; Eclectic Medical College, Cincinnati, 1886; aged 89; died May 24. Dr. Green practiced his entire career in Cleveland, retiring in 1937.

Dorrance S. James, M. D., Delaware; University of Cincinnati College of Medicine, 1924; aged 50; died May 18 while visiting in North Carolina; member of the Ohio State Medical Association and the American Medical Association; vice-president of the Delaware County Medical Society, 1929; 1930, 1946 and 1948; president, 1931, 1940, 1941 and 1947; delegate, 1925 and 1933. Dr. James began his practice in Delaware 25 years ago. He was a veteran of World War II, during which he was with the Medical Corps. He was a member of the American Legion, several Masonic orders, the Elks Lodge and was past-president of the Delaware County Reserve Officers Association. Surviving are his widow; also his parents, Dr. and Mrs. J. K. James, of Delaware.

Lloyd L. Jones, M. D., Mexico City, Mexico; Howard University College of Medicine, 1904; aged 69; died June 7. Dr. Jones formerly practiced in Columbus. He was convicted on two counts for abortion in 1946.

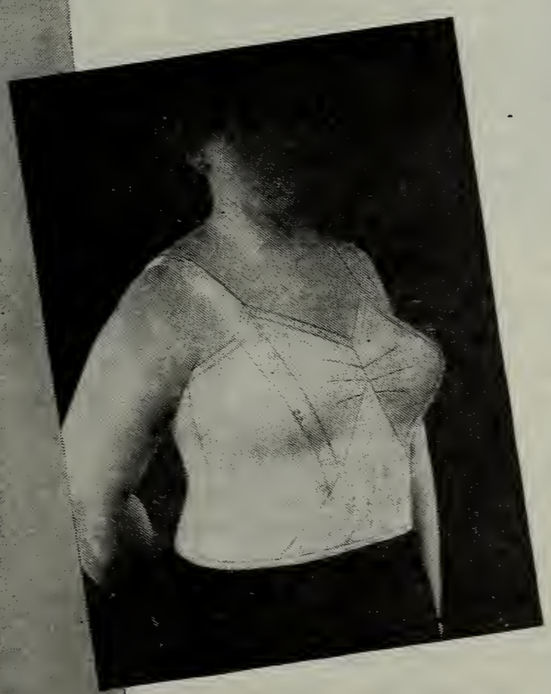
William Clyde Leeper, M. D., Chagrin Falls; Illinois Medical College, 1905; aged 68; died May 15; member of the Ohio State Medical Association and the American Medical Association through 1949. Dr. Leeper had been medical referee for the Travelers Insurance Co. in Cleveland for 25 years before retiring in 1949. In addition to his medical work, he was enthusiastic about breeding of hunting dogs and was the owner of Baron Gore, international champion Irish setter. He was a founder and active member of the Chagrin Valley Trails

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and Riding Club. Surviving are his widow, a son and a sister.

John S. Lewis, Jr., M. D., Youngstown; Jefferson Medical College of Philadelphia, 1914; aged 59; died May 19 in a boat accident while in Canada; member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1949; president of the Mahoning County Medical Society, 1923, and delegate in 1924; diplomate of the American Board of Urology; member of the American Urological Association. Dr. Lewis had practiced his profession in Youngstown continuously since being released from the Medical Corps after World War I. He was a past-president of the University Club, a trustee of the Youngstown Country Club, a member of the Masonic Lodge and the Baptist Church. Surviving are his mother and two sisters.

E. U. Marquand, M. D., Coshocton; Ohio Medical University, Columbus, 1897; aged 82; died May 4; member of the Ohio State Medical Association and the American Medical Association through 1948; president of the Coshocton County Medical Society in 1928. Dr. Marquand had practiced medicine in Coshocton for more than 50 years, about 25 years each in Conesville and Coshocton. Recently he was awarded the 50-Year Pin and Certificate of the Ohio State Medical Association. Activities included memberships in the Methodist Church and Masonic Lodge. Surviving are a son, Dr. Edgar A. Marquand, of Berwick, Pa., and three sisters.

Charles J. McDevitt, M. D., Santa Barbara, Calif.; University of Cincinnati College of Medicine, 1911; aged 62; died May 27; member of the Ohio State Medical Association and the American Medical Association through 1946; president of the Academy of Medicine of Cincinnati, 1936, and its delegate, 1941-43; diplomate of the American Board of Urology; member of the American Urological Association; fellow of the American College of Surgeons. Dr. McDevitt was a practicing physician in Cincinnati before he retired because of ill health about four years ago. Early in his career, Dr. McDevitt served with the U. S. Public Health Service, going into private practice during the middle 20's. With the outbreak of World War II, he went into the Coast Guard as a medical officer. He was a member of the Catholic Church. Surviving are his widow, two daughters, three sons, two sisters, and a brother, Dr. Lester McDevitt of Cincinnati.

Howad C. Miller, M. D., Youngstown; Western Reserve University School of Medicine, 1900; aged 73; died May 14; member of the Ohio State Medical Association and the American Medical Association. Dr. Miller had practiced in Youngstown since 1901. In addition to his medical activities, he was active in several Masonic Orders and the Presbyterian Church. Surviving are his widow, a son, a daughter and a sister.

James M. Pierce, M. D., Cincinnati; University of Michigan Medical School, 1923; aged 53; died May 24; member of the Ohio State Medical Association and the American Medical Association through 1947; diplomate of the American Board of Obstetrics and Gynecology; Fellow of the American College of Surgeons. Dr. Pierce came to Cincinnati in 1931 from the University of Michigan Medical School where he was associate professor in the Department of Obstetrics and Gynecology. In Cincinnati he was assistant professor of obstetrics at the College of Medicine. Dr. Pierce resigned his position and retired from active practice in 1948 because of failing health.

Charles Saur, M. D., North Bend; Medical College of Ohio, Cincinnati, 1901; aged 70; died May 18. Dr. Saur had practiced in Norwood for about 36 years before retiring in 1937. Surviving are his widow, one daughter and one son.

Howard Marcus Schriver, M. D., Cincinnati; University of Cincinnati College of Medicine, 1943; aged 32; died June 11; member of the Ohio State Medical Association and the American Medical Association. After completing his internship at General Hospital, Cincinnati, in 1944, Dr. Schriver was commissioned in the Navy Medical Corps where he held the rank of lieutenant. He had never recovered from an infection contracted while on duty in the Pacific Theater in 1945. Affiliations in addition to medical organizations included membership in the Disabled Emergency Officers of the World Wars. Surviving are his parents, Dr. and Mrs. L. Howard Schriver, of Cincinnati, and a sister.

Frederick Alden Waltz, M. D., Columbus; Ohio State University College of Medicine, 1942; aged 32; died May 24; member of the Ohio State Medical Association and the American Medical Association. Dr. Waltz was an instructor in surgery at the O. S. U. College of Medicine and visiting associate physician for the University Student Health Service. He was a veteran of World War II. Surviving are his widow, a son, a daughter, his father and a brother.

James W. Young, M. D., Bellefontaine; Cleveland University of Medicine and Surgery, 1896; aged 88; died May 26; member of the Ohio State Medical Association and the American Medical Association through 1929; president of the Logan County Medical Society, 1925-26. Dr. Young had practiced medicine in Logan County for approximately 54 years. Recently he was awarded the 50-Year Pin and Certificate of the Ohio State Medical Association. Dr. Young at one time operated a private hospital in Bellefontaine and was active in the founding of the Mary Rutan Hospital in 1919. A daughter, two sisters and a brother survive.

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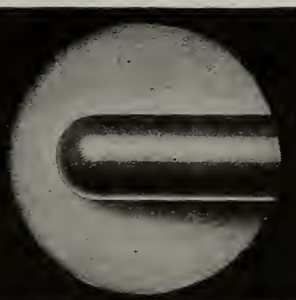
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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

HAMILTON

More than forty physicians were honored by the Academy of Medicine of Cincinnati at a meeting on May 9, at which they were presented 50-Year Pins and Certificates of the Ohio State Medical Association. Dr. David W. Heusinkveld, Councilor of the First District, made the presentations.

Those so honored are: Drs. Harry W. Behymer, Albert J. Bell, Robert Carothers, Archibald I. Carson, John B. Casello, Louis E. Cook, Harry O. Cooper, James C. Erwin, Otto P. Geier.

Drs. Arthur E. Gillette, Samuel J. Goldberg, Walter R. Griess, Thomas W. Hays, Daniel Heyn, Frederick Kattenborn, Edward C. Juler, Frank A. S. Kautz, E. M. Keefe, Edwin Khuon.

Drs. Frank E. Kugler, Sr., William C. Langdon, James T. McKibben, Edward W. Mitchell, William Mithoefer, George W. Moore, Adolph F. Morgenstern, Jacob B. Moses, Sr., William Muhlberg, Charles T. Pearce, Frank O. Perry.

Drs. Frank L. Rattermann, Samuel Rothenberg, James W. Rowe, Louis C. Schrickel, Eben B. Shewman, Henry Stanberry, Harry V. A. Spargur, William Teveluwe, John H. Thesing, Edward H. Thompson, Henry W. Wiggers, William B. Young, and Philip Zenner.

Dr. H. M. Platter, Columbus, secretary of the State Medical Board, was guest speaker for the occasion. A number of distinguished guests were present for the special dinner meeting at the Hotel Alms.

At the May 16 meeting, Dr. Cecil Striker was chosen president-elect of the Academy. A total of 475 votes were cast in the election of officers. Dr. Frank H. Mayfield, elected last year, is the incoming president.

Dr. Esther C. Marting-Fabing was elected secretary and Dr. Richard D. Bryant, treasurer. Delegates and alternates were named as follows: Dr. Joseph Lindner and Dr. Daniel C. Rivers, three-year terms; Dr. Arthur W. Wendel, delegate one-year term; Dr. J. Harold Kotte and Dr. Robert J. Tapke, alternates three year terms.

Dr. William B. Sherman, College of Physicians and Surgeons, Columbia University, was guest speaker at the May 16 meeting and spoke on the subject, "Allergy and Non-Protein Drugs."

WARREN

The regular monthly meeting of the Warren County Medical Society was held on May 2 with luncheon at the Golden Lamb, Lebanon. Dr. Frank Batsche presided.

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CLARK

A movie showing effects of the atomic bomb and treatment of casualties was shown at the May 15 meeting of the Clark County Medical Society. Speaker for the occasion was Dr. George P. Fitzgerald, Jr., Springfield, who recently attended a session in Washington on aspects of atomic explosions.

At the final meeting of the season on June 1, Dr. N. L. Burrell, Springfield, spoke on the subject, "The Science of Having a Good Time."

MIAMI

The Honorable Roscoe R. Walcutt, Columbus, Republican Senate floor leader of the 98th Ohio General Assembly, spoke on the subject, "Legislator Prescribes for Doctor," at the May 4 meeting of the Miami County Medical Society. The dinner meeting was held at the Troy Country Club with doctors' wives and other guests present.

MONTGOMERY

Hon. Roscoe R. Walcutt, Columbus, Republican floor leader for the Ohio Senate, was guest speaker at the June 7 meeting of the Montgomery County Medical Society at the Biltmore Hotel in Dayton. He discussed civic responsibilities of doctors. A social hour was followed by dinner and special entertainment.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M. D., UPPER SANDUSKY)

MARION

Dr. John R. Haserick, Department of Dermatology, Cleveland Clinic, spoke at a meeting of the Marion County Academy of Medicine on May 10, where he discussed diagnosis and treatment of common skin diseases.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

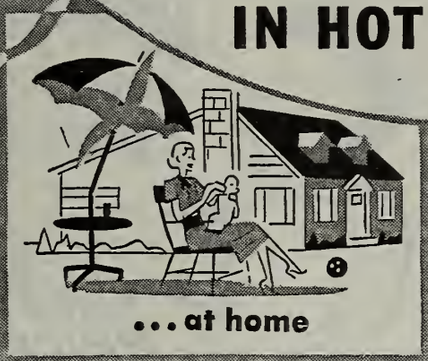
LUCAS

The program of the Academy of Medicine of Toledo included the following features during May:

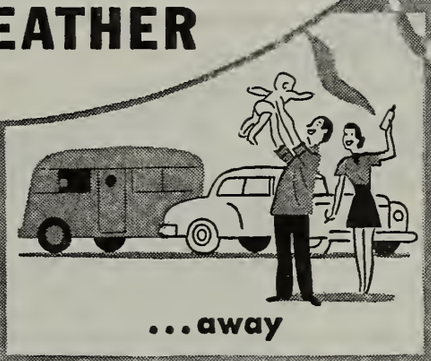
General Meeting, May 5—Preview of new Academy building.

Section on Pathology, Experimental Medicine and Bacteriology, May 12—"Clinico-Pathologic

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General Practice Section—Did not meet because of the Annual Meeting of the Association.

Medical Section, May 19—Did not meet because of the Annual Meeting of the Association.

Surgical Section, May 26—"An Experience in Psychosomatic Medicine," Dr. Herbert C. Modlin, Menninger School of Psychiatry.

WILLIAMS

Fifty-Year Pins and Certificates of the Ohio State Medical Association were presented to seven doctors at a special dinner meeting of the Williams County Medical Society at the Orchard Hills Country Club on June 6.

Dr. Carll S. Mundy, Toledo, Councilor of the Fourth District, made the presentations.

Those so honored are: Dr. Emery A. Bechtol, Montpelier; Dr. Alfred G. Goll, Stryker; Dr. James W. Long, Bryan; Dr. Orrin H. Nihart, Edon; Dr. Horace L. Prouty, West Unity; Dr. Harry W. Wertz, Montpelier; and Dr. Walter L. Unger, Bryan.

WOOD

Dr. S. A. Avery, of Toledo, addressed the Wood County Medical Society May 18 at its regular dinner meeting at the Midway Restaurant, Perrysburg. His subject was "Office Urology." Dr. Ray Whitehead presided.

Dr. Avery's material was exceptionally well organized and he discussed particularly the procedures adaptable to the routine of the General Practitioner's office. While in no case was scientific accuracy sacrificed, techniques were described in a simple manner that would enable the physician to diagnose and treat effectively a large sector of genito urinary disease.

That the members enjoyed the paper greatly was attested by the fact that nearly a full hour was given to questions and discussion after the reading. Dr. Avery's long experience as a specialist in the field enabled him to reply concisely to the questions.

A rising vote of thanks was given Dr. Avery.

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

CUYAHOGA

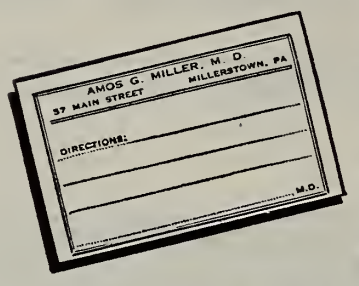
The annual distinguished service award of the Cleveland Academy of Medicine this year went to Dr. Harry V. Paryzek. The citation, read by Dr. D. M. Spicer, chairman of the awards committee, at the May 19 meeting, called the recipient "a physician whose personality has won him the respect, confidence and love of

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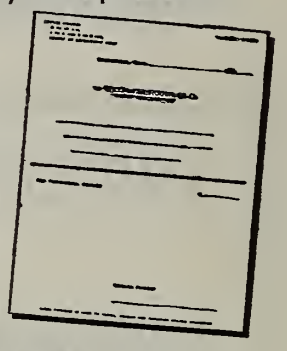
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his fellow practitioners, his patients and the community in which his life has been such a potent force." The award was given in absentia, since Dr. Paryzek was ill and unable to attend the meeting.

Dr. Paryzek has rendered innumerable services both to his county society and to the State Association. He has been president of the local society, its vice-president, a director for six years and has been chairman or member of a number of committees. He has been Councilor of the Fifth District for two terms and in 1940 was named President-Elect of the Ohio State Medical Association and subsequently became President the following year. He also served on a number of committees for the Association.

Fifty-Year Pins and Certificates of the Ohio State Medical Association were presented in person by Dr. Fred W. Dixon, acting in behalf of the Association. Those present and awarded in person are:

Drs. S. L. Bernstein, William E. Bruner, Edwin C. Froelich, John J. Friend, C. Lee Graber, Mary C. Goodwin, W. H. Hyde, Max Kahn, Benjamin B. Kimmel, Louis W. Ladd, Walter I. LeFevre, Samuel C. Lindsay.

Drs. Alfred S. Maschke, Torald H. Sollmann, David B. Steuer, H. B. Stotter, John S. Tierney, Arthur C. Taylor, Samuel J. Webster, William H. Weir, Norman C. Yarian.

The following physicians were awarded the Pins and Certificates in absentia:

Drs. Frank P. Charvat, William E. Cleveland, Herbert L. Davis, Roy C. Eddy, Frank J. Geib, Bernard Levenberg, Charles F. Nelson, Frank A. Oakley, Willis T. Parsons, Edwin H. Season and George D. Upson.

The following physicians, approved to receive the awards, are now deceased:

Drs. Thomas Burke, Ira B. Gordon, K. K. Hastings, Frank C. Kopfstein, Paul H. Krebs, and Archibald C. Nash.

Dr. Paul R. Hawley, director of the American College of Surgeons, was principal speaker for the occasion.

The Academy voted to establish a blood bank in cooperation with the Cleveland Hospital Council. The Academy made its decision after an extensive survey of needs made by a committee headed by Dr. Benjamin Kline and Dr. Francis Bayless.

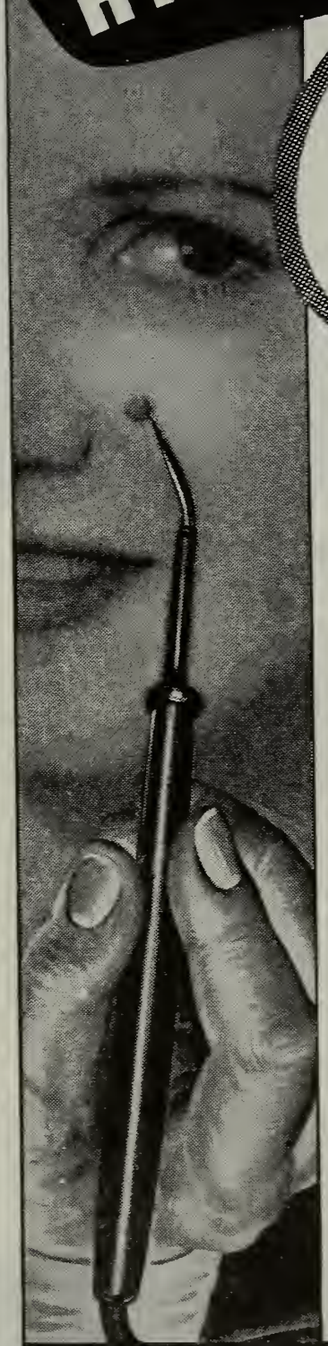
Dr. Charles S. Higley was elected president of the Cleveland Academy of Medicine at the May 26 meeting. Other officers elected are Dr. Francis Bayless, vice-president, and Dr. J. D. Osmond, Jr., secretary-treasurer (reelected).

LAKE

Dr. Howard L. Taylor, Cleveland, spoke before the Lake County Medical Society at the May 9

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meeting in Painesville on the topic, "Analgesia and Anesthesia in Obstetrics."

Dr. Marion E. Black, Cleveland, spoke before the Medical Staff and Trustees of Lake County Memorial Hospital, Painesville, on May 10. His subject was "Present Trends in Obstetrics." Dr. Paul Reading was chairman of both meetings.

A medical answering bureau for all doctors in Lake County is scheduled to be started July 1, it was announced following the June 13 meeting of the Society. The participating doctors will be covered 24 hours a day. Each physician will designate two of his colleagues to cover for him in case he is not available for calls.

Dr. Thomas Byrne, vice-president, presided at the meeting at the Painesville Hospital. Dr. B. S. Park introduced Dr. Walter B. Lacock, Columbus, chief of the Divsion of Chronic Diseases of the Ohio Department of Health, who spoke on "The Epidemiological Study of Cancer."—F. J. Dineen, M. D., Public Relations Chairman.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

SUMMIT

Two doctors of the Henry Ford Hospital, Detroit, Mich., conducted the scientific program at the June 6 meeting of the Summit County Medical Society held in the Nurses' Home of City Hospital.

Dr. Howard P. Doub, chief of the Department of Radiology, spoke on "Roentgen Aspects of Rheumatoid Arthritis and Ankylosis Arthritis of the Spine"; Dr. Dwight C. Ensign, director of the Arthritis Clinic, discussed, "Rheumatoid Arthritis; Newer Aspects of Treatment."

TRUMBULL

A joint meeting of the Trumbull County Medical Society and the Auxiliary was held at the Warner Hotel, Warren, on May 24. Dr. C. R. Brown, Warren, gave a travelogue on a recent trip to Central America including colored moving pictures.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

Dr. Edward C. Jenkins, Delaware, was guest speaker at the June 15 meeting of the Belmont County Medical Society. His subject was "Medical and Surgical Management of Diaphragmatic Hernia." The meeting was a special event at

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the Barnesville Memorial Park with a picnic dinner followed by swimming and an evening of entertainment. Members of the Auxiliary took part in the meeting.

TUSCARAWAS

Dr. S. E. Kerr, Massillon, spoke before the May 11 meeting of the Tuscarawas County Medical Society in New Philadelphia on phases of pathology. At a business session the county-wide educational nursing program was approved. Dr. W. E. Hudson, president, was in charge of the meeting.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M. D., LANCASTER)

GUERNSEY

The Guernsey County Medical Society met in regular session at noon on April 20 at the Berwick Hotel. Dr. Reo Swan, president, reported that Mr. Garver of the Guernsey County Relief Agency stated that his agency will reimburse physicians for medical services according to the fee schedule of the Division of Aid for the Aged.

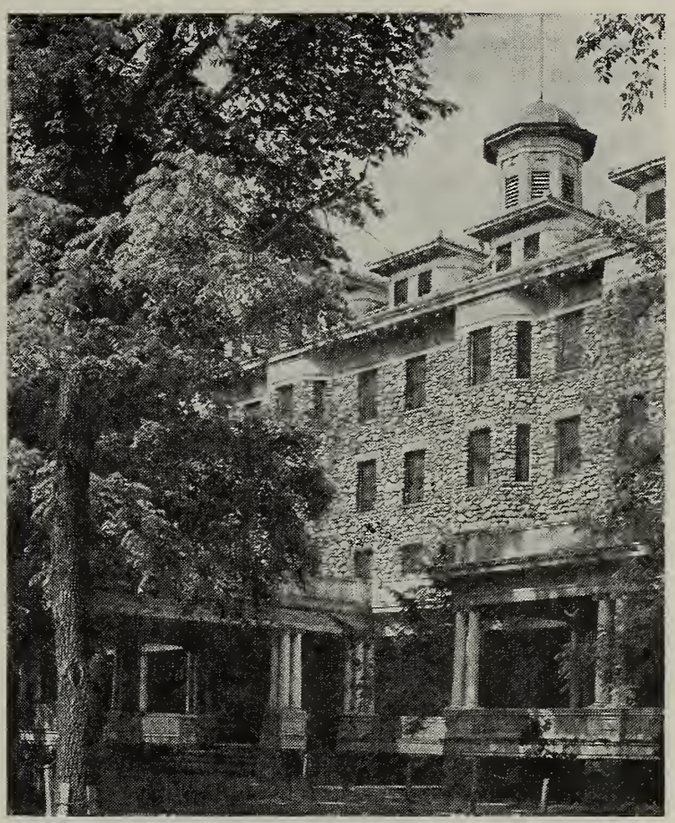
Dr. Swan also stated that he would contact Miss Margaret Brown of the Aid for Dependent Children and Aid for the Blind County Agency and would make arrangements for the Guernsey County Medical Society members to provide services for these beneficiaries, again according to the fee schedule of the Division of Aid for the Aged.

Dr. Earl E. Conaway was in charge of the scientific program and presented a very interesting and complete review of the status of B. C. G. vaccination against tuberculosis. According to his report, B. C. G. vaccine has proven effective to a practical degree in mass immunization against tuberculosis, either preventing or attenuating tuberculosis infection in a significant percentage of instances. His final thought was that B. C. G. vaccinations may eventually be used on a wide scale in the United States.

At the June 1 meeting, Dr. William W. Bryant was admitted to membership in the Society by unanimous vote.

Mr. Charles Moore, president of the Board of Trustees of Guernsey Memorial Hospital, was introduced and spoke regarding the proposed building of a combined professional building and nurses' quarters. It was stressed by Mr. Moore that it is the wish of the hospital trustees to learn whether or not such a building would be an asset to the Guernsey Memorial Hospital and whether or not a sufficient number of doctors would be interested in securing office space to justify the construction of such a building. Mr.

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Moore stated that if such a building were constructed it would be owned and operated by the hospital and that any doctor or dentist would be eligible to secure office space therein.

Post cards were distributed to all members requesting that they express their opinions regarding the proposal.

The scientific program was in charge of Dr. Robert Ringer, delegate to the Ohio State Medical Association. Dr. Ringer gave an interesting and comprehensive report of the Annual Meeting held in Cleveland, May 16-18, covering not only high lights of the House of Delegates' sessions, but also several of the scientific papers. Much thought and discussion was devoted to (1) socialized medicine, and (2) the proposed Ohio law which would provide compulsory temporary disability insurance for non-occupational illness and injuries.

Scientific papers reviewed by Dr. Ringer included those on "Obstetrical Analgesia," "Resuscitation of the Newborn," and "Metabolic Effects in Man of ACTH and Cortisone."

Dr. Swan, who also attended the State meeting, spoke on several of the interesting and educational features which he attended.—Gordon Lawyer, M. D., secretary-treasurer.

MUSKINGUM

At the June 7 meeting of the Muskingum County Academy of Medicine, Dr. Ward D. Coffman, Chicago, described gynecological diagnostic procedures at the Chicago Lying-in Hospital. Members of surrounding county societies were guests at this meeting in Zanesville.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

SCIOTO

Dr. Jonathan Forman, Columbus, Editor of *The Ohio State Medical Journal*, spoke on the subject, "Soils, Food, and Health," at the June 12 meeting of the Hempstead Academy of Medicine. The meeting was held in the Nurses' Recreation Hall, General Hospital, with a buffet luncheon.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

ERIE

Three doctors were honored for more than 50 years of medical service by the Erie County Medical Society at a special meeting held in the Providence Hospital, Sandusky. They were each presented the 50-Year Pin and Certificate of the Ohio State Medical Association. The three honored doctors are: Dr. W. A. Crecelius

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and Dr. Emily Blakeslee, both of Sandusky, and Dr. William T. Sullivan of Kelleys Island.

Dr. John S. Hattery, Mansfield, Councilor of the Eleventh District, made the presentations. Dr. Herbert H. Johnson, Cleveland, was guest speaker for the occasion. The meeting was held on May 25 with members of the Auxiliary present.

LORAIN

Dr. Harry R. Trattner, Cleveland, was guest speaker at the June 13 dinner meeting of the Lorain County Medical Society at the Lorain Country Club. His subject was "Diseases of the Prostate."

MEDINA

Activities of the Medina County Medical Society included the following programs during 1950:

Jan. 19—Lecture by Dr. J. E. Brown, Cleveland; subject, "Fractures of Lower Extremity."

Feb. 16—Lecture by Dr. R. F. Jukes, Akron Clinic; subject, "Management of Heart Failure."

March 23—Lecture by Dr. Robert E. Brubaker, Akron Clinic; subject, "Pitfalls of Gall Bladder Surgery."

April 20—Dr. J. E. Brown concluded a series of interesting lectures on the "Treatment of Fractures."—Herbert F. Cowgill, M. D., Secy.

RICHLAND

Members of the Richland County Medical Society and the Medical Staff of Mansfield General Hospital met at the hospital on May 25 for a dinner meeting. A short business meeting followed the dinner, after which the program was presented.

The speaker was Dr. William D. Holden, professor of surgery, Western Reserve University School of Medicine. His subject was, "Problems in Diagnosis and Treatment of Peripheral Vascular Diseases."—C. O. Butner, M. D., secretary.

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ASHTABULA

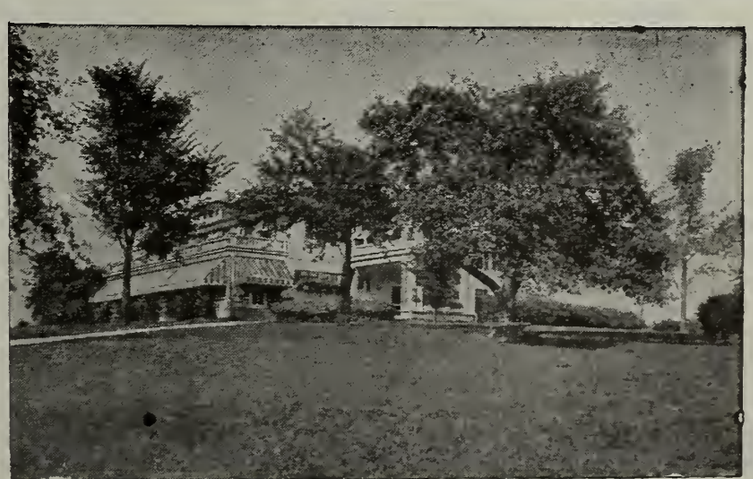
Mrs. Paul Longaker was elected president of the Woman's Auxiliary to the Ashtabula County Medical Society at a dinner meeting on May 16 held at the Hotel Ashtabula. There will be no further meetings until fall. Also elected to office at the May meeting were: Mrs. John O'Bell as president-elect; Mrs. E. N. Wright, vice-president; Mrs. James Macaulay, secretary; and Mrs. Richard Irving, treasurer.

ERIE

The Plum Brook Country Club was the scene in April of "The Doctors' Party" given by the Erie County Auxiliary for members of the County Medical Society. Program participants were introduced by Mrs. E. J. Meckstroth, general chairman. Musical selections were presented by five members of the Sandusky High School band. "The Clintonaires," a quartet, sang a group of harmony numbers. Principal speaker of the evening was Lou Klewer, outdoor editor of the *Toledo Blade.* Mr. Klewer, a country-wide traveler, supplemented his vivid account of a recent visit to Alaska with interesting and scenic colored films.

Assisting Mrs. Meckstroth on the committee were Mrs. W. F. Burger, Mrs. Herbert Kesinger, Mrs. W. R. Liebschner, Mrs. Watson Parker and Mrs. Ross Knoble.

The Erie County Auxiliary ended its 1949-50



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season on May 8 with a luncheon and installation of officers at the Business Women's Club. The new officers, installed by the retiring president, Mrs. Carl E. Swanbeck, included: Mrs. E. J. Meckstroth, president; Mrs. H. W. Lehrer, president-elect; Mrs. Paul N. Squire, vice-president; Mrs. C. J. Reichenbach, secretary; and Mrs. A. G. Groscost, treasurer. A musical program was presented by the Almar Trio.

FAIRFIELD

The May meeting of the Auxiliary to the Fairfield County Medical Society was a tea given for the junior and senior girls of city and county schools at the Nurses' Home, Lancaster-Fairfield Hospital. The tea is an annual event, as part of the nurse-recruitment program. Mrs. Galen Rodabaugh introduced the speaker, Miss Florence Steel, who told the young women of the requirements of a student nurse. Miss Steel is nursing arts instructor at the local hospital.

Subsequently, a tour of the hospital was conducted by student nurses for the girls, after which tea was served. Mrs. Chester P. Swett and Mrs. W. S. Jasper presided at the table. Mrs. Rodabaugh was general chairman for the event, with Mrs. Jasper and Mrs. C. F. Clark as her assistant chairmen.

HURON

Mrs. William Kauffman was elected president of the Huron County Auxiliary at its luncheon

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meeting on May 12 at the home of Mrs. George Linn. Chosen by the Auxiliary to serve with Mrs. Kauffman were: Mrs. Clyde Cranston, president-elect; Mrs. Walter Drury, vice-president; Mrs. John Emery, secretary; and Mrs. C. H. Edel, treasurer.

The group voted to sponsor a student nurse. The scholarship will be given to the high school student who rates in the upper third bracket of her class at graduation. Mrs. C. E. Swanbeck, district director, attended the May meeting and addressed the auxiliary members.

KNOX

The Woman's Auxiliary to the Knox County Medical Society closed its meetings for the season with a luncheon at the Alcove on May 26. Mrs. James F. Lee and Mrs. John C. Woodland were hostesses.

Mrs. J. L. Baube presided at the business session. Mrs. Charles Tramont reported on the state convention at Cleveland, and Mrs. O. W. Rapp, *To-Day's Health* chairman, announced that the Knox County Auxiliary had won a prize of ten dollars in the state-wide contest making first place in the Group II classification.

Tentative plans were made for a display booth on health at the Knox County Fair. Mrs. Henry Lapp, chairman of the nominating committee, announced these officers for the coming year: president, Mrs. C. E. Cassaday; president-elect, Mrs. Alexander Mack; vice-president, Mrs. I. S. Rian; secretary-treasurer, Mrs. Richard Gomer.

LICKING

The Hotel Warden was the scene on May 23 of the dinner meeting of the Licking County Auxiliary. Mrs. Roland Jones, president, presided at the business session and presented an interesting resumè of the Cleveland convention. Guest speaker was Miss Rosemary Kuster who, two years ago, was awarded the nursing scholarship presented annually by the auxiliary. Miss Kuster reviewed her work at the Good Samaritan Hospital School of Nursing in Cincinnati.

LOGAN

The Logan County Auxiliary concluded its season's program with a covered dish luncheon May 23 at the home of Mrs. Warren Mills. Mrs. Blair Webster conducted the business meeting. Mrs. Mills reported on the state convention at Cleveland. New officers chosen for the coming year included: Mrs. C. K. Startzman, president; Mrs. Hobart Mikesell, vice-president; Mrs. John B. Traul, secretary; Mrs. John Maurer, treas-

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urer; and Mrs. A. J. McCracken, corresponding secretary.

PICKAWAY

The Woman's Auxiliary to the Pickaway County Medical Society held its May meeting at the home of Mrs. Walter Heine. A report of the state convention at Cleveland was given, and memberships on standing committees announced. Plans were made for a covered dish luncheon to be held in June.

RICHLAND

Mrs. H. G. Knierim was installed as president of the Richland County Auxiliary at its annual meeting on May 22 at the Women's Club. Other officers installed with Mrs. Knierim were: Mrs. Charles Brown, Sr., president-elect; Mrs. A. H. Voegele, vice-president; Mrs. Robert Pierce, recording secretary; Mrs. Sigmund Smedal, corresponding secretary; and Mrs. Milton Oakes, treasurer.

Mrs. F. J. Heringhaus, the retiring president, conducted the business session. Annual reports and state reports were given, and a letter of commendation was read from Dr. Harry Wain for the Auxiliary's participation in the well baby clinic during the past year. Mrs. Robert Crawford and Mrs. F. M. Wadsworth were named as members of the citizens' committee for the council for the summer months.

The luncheon tables were attractive with arrangements of lilacs and tulips. Mrs. Robert Pierce and Mrs. Leonard Hautzenroeder served as hostesses.

A. M. A. Distributes 1,912 Films

Ralph P. Creer, secretary of the A. M. A. Committee on Medical Motion Pictures, reports that a total of 1,912 films were shipped to various medical groups during 1949 as compared with 1,750 in 1948. His report shows that 45 medical societies used 177 films; 54 medical schools, 408 films; 36 veterans administration hospitals, 205 films; 190 civilian hospitals, 624 films; 10 service hospitals, 53 films, and miscellaneous groups, 445 films.

The American Congress of Physical Medicine will hold its 28th annual scientific and clinical session August 28 - September 1, 1950, at the Hotel Statler, Boston, Mass. All sessions will be open to members of the medical profession in good standing with the American Medical Association. Further information may be obtained by writing the Congress at 30 N. Michigan Ave., Chicago 2, Ill.

The annual convention of the National Society for Crippled Children and Adults will be held October 26-28, 1950, at the Stevens Hotel, Chicago. Further information may be obtained from the Society at 11 S. LaSalle St., Chicago 3.

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GYNECOLOGY—Intensive Course, two weeks, starting Sept. 25. Vaginal Approach to Pelvic Surgery, one week, starting Sept. 18.

OBSTETRICS—Intensive Course, two weeks, starting Sept. 11.

MEDICINE—Intensive General Course, two weeks, starting Oct. 2. Gastro-enterology, two weeks, starting Oct. 16. Gastroscopy, two weeks, starting July 17, Sept. 25.

DERMATOLOGY—Formal Course, two weeks, starting Oct. 16. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, two weeks, starting Sept. 25. Cystoscopy, Ten Day Practical Course, every two weeks.

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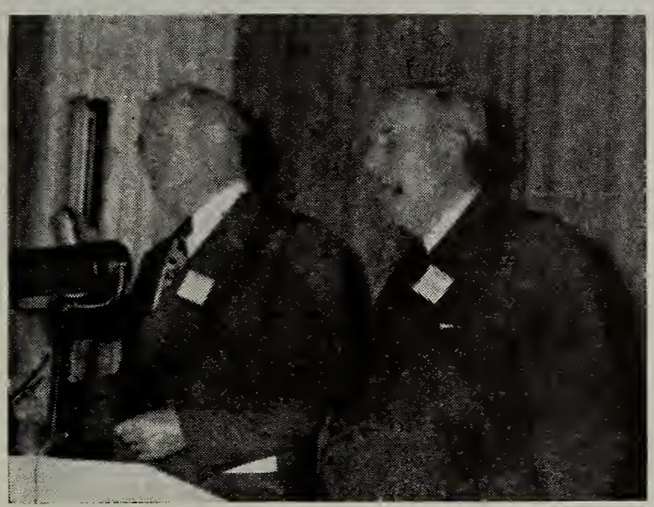
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Dr. Wilzbach Named President of Ohio Public Health Association

Dr. Carl A. Wilzbach, Cincinnati, chairman of the Committee on Education of the Ohio State Medical Association, and Cincinnati health commissioner, became president of the recently organized Ohio Public Health Association at a meeting of that organization in Columbus May 11 and 12.

Dr. Wilzbach succeeded Dr. F. E. Mahla, Toledo, health commissioner of Lucas County,



Dr. F. E. Mahla (right) is shown as he relinquished the presidency of the Ohio Public Health Association to Dr. Carl A. Wilzbach at the annual meeting in Columbus.

who was chosen as president at a meeting in October, 1949, during which the Association was brought into existence as an outgrowth of the Ohio Federation of Public Health Officials.

The Association chose Vera Glover, R. N., of Cuyahoga County General Health District, as president-elect, and Dr. Harry Wain, Mansfield, Richland County health commissioner as delegate to the American Public Health Association. W. R. Haines, Sanitarian, Northwest District Office, Ohio Department of Health, Bowling Green, was reelected as secretary.

Dr. Jonathan Forman, Editor, *The Ohio State Medical Journal*, spoke before the Health Commissioners' section of the meeting on "Introduction of Asiatic Cholera into Ohio." Other speakers at the Association's meeting included Dr. Granville W. Larimore, director of public health education, New York State Health Department; Mr. Raymond Lenart, Extension Service Consultant, the Ohio State University; Elizabeth Lovell, M. P. H., director of public health education, North Carolina State Board of Health; Dr. Henry Eisenberg, medical officer in charge of the Central Ohio Rapid Treatment Center; Dr. John A. Prior, associate professor, Departments of Medicine and Preventive Medicine, Ohio State University College of Medicine; and Dr. Thomas E. Parran, dean, Graduate School of Public Health, University of Pittsburgh.

Registration for the meeting was approximately 450. Members voted to present recognition awards each year for outstanding work in public health.

The Executive Committee of the A. M. A. selected Dr. Austin Smith, editor of the *A. M. A. Journal*, to serve in the Division of Medical Sciences of the National Research Council. He succeeds Dr. R. L. Sensenich, South Bend, past-president of the A. M. A., who could not succeed himself as a representative of the council. Dr. Smith will serve a three-year term, ending June 30, 1953.

A one-day seminar on heart and circulatory diseases was held by the Southwestern Division of the Ohio Academy of General Practice at the Gibson Hotel in Cincinnati on May 14.

Dr. Maurice Levine, head of the Department of Psychiatry, University of Cincinnati College of Medicine, has been designated to head an estimated 300 American psychiatrists who will attend the first International Congress of Psychiatry, Sept. 18-26, in Paris, France. He was elected as president of the American delegation by the delegates. At the Congress he will lead a seminar on the development of American psychiatry in the last 20 years.



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Federal Income Tax Laws Unfair To Professions, Says Economist

Present Federal income tax laws discriminate against physicians and other professional men and women, Frank G. Dickinson, Ph. D., Chicago, economist and statistician of the American Medical Association points out.

Because a considerable portion of physicians' lifetime earnings are "bunched" into a relatively few peak earning years they pay more income taxes than other persons who receive the same lifetime incomes spread more evenly over a greater number of years, Dr. Dickinson says in an article in a recent issue of the *Journal of the A. M. A.*

This discrimination in lesser degree applies to a number of other professions, according to the article.

"A physician undergoes a long training period (the longest among the professions) during which he foregoes income and incurs expenses accumulating to approximately $35,000 at the time of entering medical practice, at approximately age 28," Dr. Dickinson says. "The working lifetime remaining after this prolonged period is shortened.

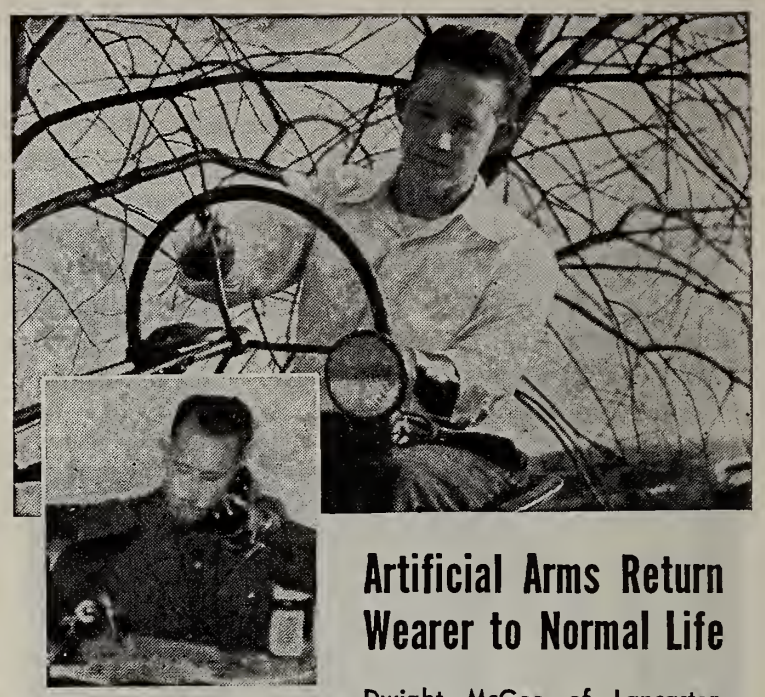
"To pay off this investment in training in annual installments, his annual gross earnings would have to be at least $5,000 more than those of a person whose earning period started at age 18.

"Under the 1942 Federal Internal Revenue Code, funds used by companies for the purpose of providing employees with pensions or shares in profit-sharing trusts are deductible from gross receipts as business expenses and thus are not a taxable part of the employer's or company's income, if the particular plan is approved by the Bureau of Internal Revenue.

"Since the provisions are restricted to employees, professional men who can qualify as employees—for example, company lawyers and company physicians—can receive the benefits of these pensions and profit-sharing trusts, while those who conduct their professions as single proprietorships or partnerships may not qualify for these benefits.

"The Board of Trustees of the American Medical Association authorized its representatives to record, at a meeting of the Association of the Bar of the City of New York, its support, in principle, of the proposal that the Internal Revenue Code be amended to permit physicians who practice as individual proprietors or partners to declare as business expenses the costs of pension programs for themselves, with the proviso that there should be a reasonable maximum pension.

"The American Medical Association believes that such an amendment would appreciably reduce the present discrimination."



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Dwight McGee of Lancaster, Ohio, wearing two Hanger Arms, can write, shave, use a knife and fork, drive an automobile, and says he can do about anything an ordinary person can do. Hanger Arms are custom-made to fit the wearer's stump and his particular daily needs, and are carefully fitted by experienced Hanger fitters. Arms can be furnished with cosmetic or mechanical hand and hook.

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Patients Who 'Pay' Get Service Under 'Free' British Medical System

The following letter which describes phases of the British Medical system was relayed to the Headquarters Office by a Columbus physician. It was written to a New Jersey doctor by a former patient. As the doctor who forwarded the letter remarked, "if the proof of the pudding is in the eating thereof, the English pudding seems to be a particularly unsavory failure in this case."

December 15, 1949

Dear Doctor . . .:

Today I read in the European Edition of the *Herald Tribune* an article that so angered me that it prompted this letter to you, as secretary of the . . . Medical Association and, of course, as the doctor who delivered our second baby on April 15, 1946. . . .

Our family has been living in England for over three months and my husband was here an additional three months this summer. So far **we have had four different physicians attend us personally** and we have heard the comments of numerous American and British friends on their medical attention here. So when Mr. Oscar Ewing comes to England for **one** week to study "British problems in the fields of health, education and social welfare," talks with five doctors, and then proceeds to say that "the British service is a 'terrific success' as far as the patients are concerned" and that the "program has been misrepresented by so many Americans who should know better," I feel personally called upon to object.

Before coming over here, we were mildly, but inactively, opposed to socialization of medical care in the United States; but **now we feel that we should warn the voters at home of the horrible consequences if they should accept such a program.** Here are some examples taken from many instances that we know are true and unexaggerated accounts of what happens in the average English family.

First of all, to have a baby in a hospital you must make all arrangements thirteen months *(sic)* in advance. Someone might think that this is necessary because of crowded conditions, **but if you pay as a private patient, as an American friend of mine did, you may get a room almost immediately.** My friend reported that during her stay in the hospital **the attending doctor left the actual delivery of all babies to a nurse,** including one breech and one premature delivery. She could not help concluding that the only reason he personally delivered her baby was that she was paying as a private patient. **When the government pays the bill, there is little reason for the patient being satisfied and no recourse if he is not.**

A British executive we know has been wearing cracked glasses with adhesive tape holding one lens together. He explained that after waiting weeks for an eye examination, he was given a **prescription for new glasses that would be filled in six months.** He knew that he was paying indirectly for these glasses and didn't want to buy a pair privately thereby paying twice. **He could have bought a new pair privately within two weeks.**

When we Americans want dental care in England, we call up for an appointment as a private patient and see the dentist within a week's time; but an Englishman waits five to six months under the medical plan. Incidentally, I have yet to hear of a foreigner taking advantage of the free medical attention which he could get here.

A British lady told me recently that she ought to have a large growth on her lip removed, because it was irritating as well as unsightly. She was reluctant to go to a surgeon as a patient under the so-called plan, **because she knew that he would not do the job himself,** but would let one of his assistants do it. However, she knew that she could receive his attention as a private patient, and thus be assured of a good job while paying for it.

Summing up the patient's viewpoint, let me

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say that **he has little choice of doctors,** no way of getting medical supplies or attention when they are needed, and no reason for satisfaction from the doctor or the hospital treating him. **When he lets the government pay the bill, he surrenders the innate power of his own purse.**

I realize that this is a sketchy picture and one that is purely from the patient's viewpoint; but I am sure that you know already the mechanics of the British medical plan, and the doctors' side of the story. It occurred to me that I had not read much in the A. M. A.'s publicity campaign which gave the patient's reaction to socialized medicine, hence this outburst.

Before we left the States, several doctors we know asked us to let them know how we liked the British medical plan. This letter answers that question in part. We want to send to them and to you our best wishes for a merry Christmas and a happy New Year **without socialized medicine.**

Sincerely,

Fifteen Million Veterans Benefit Under GI Bill

June 22 was the sixth birthday of the GI Bill, a law passed in 1944, to help World War II veterans get back into the swing of civilian living.

During the six years the act has been in effect, a majority of the nation's 15,300,000 World War II veterans have benefited by one or more of its three major provisions.

Those provisions are education and training at Government expense; Government-guaranteed and insured loans for homes, farms and businesses, and a readjustment allowance program to help tide veterans over during periods of unemployment or slack self-employment.

Some 7,000,000 ex-servicemen and women, at some time or another, have attended school or trained on-the-job or on-the-farm under the law's educational provisions. This program so far has cost more than $10 billion for tuition, supplies and subsistence allowances.

Altogether, the veterans spent a total of 95,000,000 months in the classroom, at the work bench and on the farm, or an average of about 15 months of training per veteran.

Only four per cent of all veterans who have been in training—or around 300,000—have exhausted their entitlement to further GI Bill training.

Under the law, most veterans must start their courses by July 25, 1951, if they want to continue on after that date. The final cut-off, for most veterans, comes on July 25, 1956.

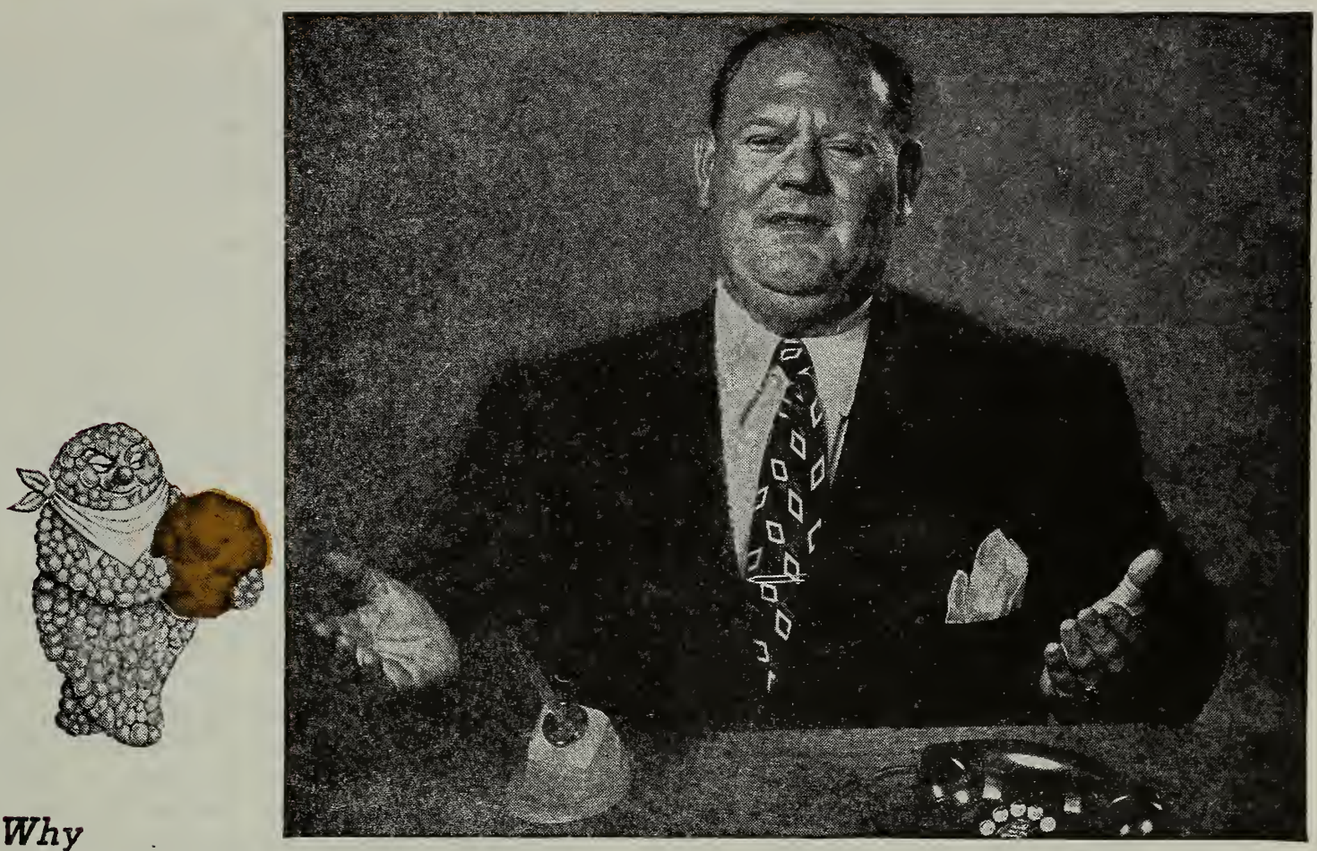
More than $11 billion of GI loans have been obtained by 2,100,000 World War II veterans during the six years of the GI Bill.

Ninety-two per cent of the veterans' loans, or 1,940,000, were for homes. Another 121,000 were for businesses, and the remaining 57,500 were for farms and farm equipment.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Attorneys' Textbook of Medicine, by Roscoe N. Gray, M. D. ($35.00. Two Volumes. Third Edition. *Matthew Bender & Company, Inc., Albany, N. Y.).* The author, who is Surgical Director of Aetna Casualty and Surety Company, has revised the 1940 edition in order to include the medical and surgical advancements which have increased with unusual rapidity during and after World War II. The section on mentality has been expanded, and new chapters written on amnesia, apoplexy, epilepsy, and alcohol tests for drunkenness. Brain activity as demonstrated by the electroencephalogram is discussed. Chapters generally deal with the cause, symptoms, diagnosis, and treatment of the disorder involved, with an additional title "Investigation" containing advice regarding the legal manifestations. At the end of each chapter are extensive bibliographical references.

The author points out that doctors and lawyers hold key positions in the administration of liability and compensation claims, and upon their ability the jury or commission depends for a clear understanding of the facts, both legal and medical. Therein, lies the importance of this text, not only to the attorney, but to the physician.

The two volumes include 186 chapters and a comprehensive index, each separately stitched, and easily removable from the sturdy leather binding if convenience indicates.

Dr. Gray's Attorneys' Textbook of Medicine is extremely worth-while reading and is highly recommended to all physicians in Ohio who are particularly concerned with industrial insurance, general disability and workmen's compensation cases.

Progress in Allergy, edited by Paul Kallos, Halsingborg, Sweden. ($7.50. Volume II. *S. Karger, Basel, Switzerland, Interscience Publishers, Inc., New York City, Agents),* again illustrates the difficulties of producing a yearbook on an international basis. It always seems to be impossible to secure uniformity in the quality of the various papers, and the most famous man does not always set the standard. Nevertheless this is a book well worth having. Others have objected because authors have been permitted to air their own particular hobbies. Your reviewer can see no objection to this for if this objection were followed to its logical conclusion, then our medical literature would consist of one text in each field assembled by a committee. There would be no medical magazines and very little program. In keeping with the history of allergy, most of the contributors are Americans. Books such as this seem to me to be the best methods in which to get a look at the progress of a specialty the world over. This is especially true in a rapidly developing field such as allergy.

Black's Medical Dictionary, by J. D. Comrie, M. D., edited by W. A. R. Thomson, M. D. ($5.50. Nineteenth Edition. *The Macmillan Co., New York City),* lands somewhere between a technical dictionary of medicine and a guide to domestic treatment of the more common ailments. It gives information in intelligible language on medical subjects of general interest. This edition incorporates recent advances in all branches of medicine and discards out-of-date material.

The Common Form of Joint Dysfunction, by William Kaufman, M. D., *(E. L. Hildreth & Co., Brattleboro, Vermont),* is a discussion of its incidence and treatment. This is a monograph recording the observations made in private practice over a period of years. Objective measurement of impaired joint mobility is carefully measured and recorded to show that it is corrected or greatly relieved by adequate niacinamide therapy and recurred in time when this treatment was discontinued.

Length of Life, by Louis I. Dublin, Alfred J. Lotka and Mortimer Spiegelman ($7.00. *Ronald Press, New York City),* is a sound statistical study by the chief of statistics for the Metropolitan Life Insurance Company. The authors trace and interpret the improvements in health and longevity from the earliest times to the present. The authors predict the addition of another five years to life expectancy in the United States by 1975.

Infection and Sepsis in Industrial Wounds of the Hands, A Bacteriological Study of Aetiology and Prophylaxis, by R. E. O. Williams and A. A. Miles (ls 6d net. *His Majesty's Stationery Office, London, England),* is an official summary of the British experiments and experiences from 1942 up to 1945 of war wounds.

The Diagnosis of Pancreatic Disease, by Louis Bauman, M. D. ($5.00. *J. B. Lippincott Co., Philadelphia),* is a much needed monograph discussing the function tests and their application in the diagnosis of disease of this organ. The author brings together twenty-five years of clinical and teaching experience in the task of writing this book.

Brain and Behaviour, by N. E. Ischlondsky, M. D. ($7.00. *C. V. Mosby Co., St. Louis, Mis-*

souri), is an experimental and clinical study of induction as a fundamental mechanism of neuropsychic activity with consideration of the educational, mental-hygienic, and social implications.

A Short Practice of Surgery, by Hamilton Baily, F.R.C.S., and R. J. McNeill Love, F.R.C.S. ($10.00. Eighth Edition. *Williams & Wilkins Co., Baltimore, Maryland)*, is written in the concise yet precise manner of the British surgeons. The illustrations, 1,198 in number, of which 280 are in color, are outstanding showing how very small cuts can be used successfully if they happen to illustrate a fact.

It Pays To Be Lazy, by Lester F. Miles, Ph. D. ($2.50. *Wilfred Funk, Inc., New York City)*, shows you the easy way to get what you want. The book is one long sermon about having faith in yourself and your abilities and finding the easy way out of any hindering feelings of inferiority.

Oral Bacterial Infection: Diagnosis and Treatment, by Lyon P. Strean, D. D. S., Ph. D. ($5.50. *Dental Items of Interest Publishing Co., New York City)*, presents the author's well-known lecture in a form readily available for reference. It covers the basic information in practical fashion.

Patterns of Panic, by Joost A. M. Meerloo, M. D. ($2.00. *International Universities Press, Inc., New York City)*, answers many questions for those who have to do with fear and panic. In this atomic age, it behooves every physician to concern himself with the mental mobilization of men. The author is a physician with considerable experience in the field of warfare and its impact upon the emotions of a people.

New Discoveries in Medicine: Their Effects on Public Health, by Paul R. Hawley, M. D. ($2.50. *Columbia University Press, New York City)*, are Bampton Lectures. The author is well known to all of us for his work in Veterans Administration, Blue Cross, and now with the American College of Surgeons. The lectures cover "Our Fabulous Blood," "Modern Surgery of the Heart and Lungs," "Modern Prevention and Treatment of Mental Disease," and "The Socio-Economic Aspects of Medical Care." This last chapter is particularly valuable at this time coming as it does from a brilliant and experienced mind.

Freud: His Life and His Mind. A biography by Helen Walker Puner ($1.49. *Grosset & Dunlap, Inc., New York City)*, is just that. Every physician should know well the life of this man so that he may appraise for himself the teachings of this man—who he was, what he contributed—so that he may make up his own mind as to whether or not this is another medical cult based upon the ancient formula: One master, one book, one cause, one cure.

Your Diet for Longer Life, by James A. Tobey, Dr. P. H. ($3.50. *Wilfred Funk, Inc., New York City)*, records the information which the author gave out over the radio assisted by a "fan mail" of 100,000 letters. It is a valuable review in non-technical language of modern knowledge of food and nutrition.

Practical Neurological Diagnosis, by R. Glen Spurling, M. D. ($5.00. *Charles C. Thomas, Publisher, Springfield, Ill.)*, deals especially with the problems of neurosurgery and is designed for practitioners who wish to become more proficient in this field by giving them the basic principles.

Menstruation and Its Disorders, edited by Earl T. Engle ($6.50. *Charles C. Thomas, Publisher, Springfield, Ill.)*, is actually the proceedings of the conference held under the auspices of the National Committee on Maternal Health. Fourteen authoritative essays are presented which deal with this aspect of human fertility.

Living Through the Older Years, edited by Clark Tibbitts ($2.00. *University of Michigan Press, Ann Arbor, Mich.)*, presents the proceedings of the Charles A. Fisher Memorial Institute on Aging, in eleven lectures which stick quite closely to the topic dealing with the biologic, psychologic and social problem of the aging.

Penicillin, under the general editorship of Sir Alexander Fleming ($7.00. Second edition. *C. V. Mosby Co., St. Louis, Mo.)*, gives us the practical application of this wonderful antibiotic. The book presents the 1946 text thoroughly revised, rewritten, and enlarged. Another book of reference that most physicians can use handily and one every intern library should have.

Consumption of Food in the United States 1909-1948 (65 cents. *U. S. Department of Agriculture Miscellaneous Publications No. 691, Washington, D. C.)*, brings together for the first time detailed information on the per capita consumption of all major food commodities in the United States, including the basic data on supplies and distribution from which consumption estimates are derived. An essential volume for all who are interested in feeding America from any angle whatsoever.

The 1949 Year Book of Dermatology and Syphilology, edited by Marion B. Sulzberger, M. D., and Rudolph L. Baer, M. D. ($5.00. *Year Book Publishers, Inc., Chicago, Ill.)*, presents as always an outstanding first chapter for the education of the general physician. This time, it is acne and its management. It is a summary that your reviewer just could not practice without. It brings one up to date on Eczematous Dermatitis, Allergic Skin, Drug Eruptions, Fungus Infections.

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The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.

Vol. 46 August, 1950 No. 8

JONATHAN FORMAN, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Chloromycetin Treatment of Typhoid Fever

JOHN A. PRIOR, M. D., C. T. KASMERSKY, M. D., and GEORGE HUMMEL, M. D.

THE new antibiotic chloromycetin (Chloramphenicol) is derived from *Streptomyces venezuelae*, a fungus recently identified in the laboratory of Dr. Paul Burkholder, who demonstrated its antibacterial effect. Since its discovery, chloromycetin has been synthesized in crystalline form by Ehrlich[1] and his associates. It is neutral in reaction and very stable, relatively resistant to heat and unaffected by wide variations in pH. Chloromycetin is unique among antibiotics in that it contains both nitrogen and nonionic chlorine. Serum levels that are obtained following oral administration compare favorably with those obtained by parenteral injection, indicating that the drug is well absorbed from the gastrointestinal tract. It is rapidly excreted or inactivated by the body. Serious toxic manifestations following oral administration have not been reported.

Chloromycetin has a wide range of usefulness. It has been shown to be effective in the treatment of Rickettsial infections, such as Rocky Mountain spotted fever, epidemic and endemic typhus, and scrub typhus. Gram-negative bacillary infections, such as brucellosis, tularemia, and those due to the *Salmonella* group also respond well to chloromycetin. In addition, preliminary reports indicate that it may prove to be of value in the treatment of the psittacosis-lymphopathia venereum group and primary atypical pneumonia. Woodward, et al.,[2] reported in 1948 the first clinical trial of this new antibiotic in the treatment of 10 patients with typhoid fever on the Malayan peninsula where the disease is endemic. Their results indicate that chloromycetin favorably influences the course of the disease with rapid defervescence, relief of subjective complaints and eradication of *Salmonella typhosa* from blood, feces and urine. Those treated on the ninth day of disease had normal temperatures within 3.5 days, whereas untreated control patients had an average of 26 days of fever after the corresponding day of illness. This report was of momentous importance to the medical profession which in 1948 had nothing more specific to offer the patient with typhoid fever than it had in 1900.

The purpose of this communication is to re-

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port further experiences and results in the treatment of typhoid fever with chloromycetin.

TYPHOID—A RURAL DISEASE

The twelve patients included in this study represent sporadic cases of typhoid fever admitted to the Contagious Disease Service of University and Children's Hospitals, Columbus, Ohio, since February 1, 1949. These patients came principally from farms and small rural communities in Central Ohio, within a radius of fifty miles of Columbus. Of this group six were children and six were adults. The children ranged from twenty-two months of age to thirteen years, and the adults varied from twenty-three to forty-two years. Seven of the patients were females and five were males. In nine patients the source of infection was traced to contaminated well water; in one patient, a nurse, the disease was contracted while caring for a patient who subsequently was shown to have typhoid fever; and in two patients, the source of infection could not be determined definitely.

The total duration of illness before admission to the hospital varied from two to twenty-one days with an average of 12.2 days. The average duration of illness before the institution of chloromycetin therapy was 14.3 days. Thus, in the usual case, the diagnosis of typhoid fever was established and the treatment was begun within an average of 2.1 days after admission.

In this series, the diagnosis of typhoid fever was established in every case by the isolation of *Salmonella typhosa* from the blood, feces or both. Eleven of the twelve patients had blood cultures showing *Salmonella typhosa*, four of whom also showed the presence of typhoid organisms in their stools. In one patient, the causative organisms were found only in the feces. Typhoid O agglutinins were present in significant titer (1:80 or more) in all of the adult cases. The agglutination titers in children tended to be lower and to develop more slowly than in adults. Typhoid O agglutinin titers taken on admission in the children ranged from a low of 1:10 to a high of 1:128. It is probable that higher titers would have been found if serial determinations had been made.

As soon as the diagnosis was established, a large initial dose of chloromycetin (50 milligrams per kilogram of body weight) was given orally in all cases. This relatively large dose was given at one time in children, whereas in adults one-third of the dose was given at hourly intervals until the entire amount had been administered. As a rule, the children received proportionately a larger maintenance dose than did the adults. Following the first dose, the children received 0.25 gram every four hours for a period of eight to ten days, irrespective of size, age or clinical response. The adults, on the other hand, received 0.25 gram every two hours until the temperature returned to normal, after which time the same amount was given every four hours for a minimum of five days. In children the average dose of chloromycetin was 80.8 milligrams per kilogram per day, while that of the adults averaged 40.5 milligrams per kilogram per day. The antibiotic was administered for an average of 9.50 days, ranging from a minimum of seven days in one patient to a maximum of twelve in two other patients. Even in the children who received relatively large amounts, no untoward reactions to the chloromycetin were observed.

CLINICAL RESPONSE IS RAPID

In every patient the results of chloromycetin therapy were very gratifying. The body temperature returned to normal within an average of 3.16 days after the beginning of treatment. Of the 12 patients in this group, eight had normal temperatures within seventy-two hours or less after the institution of treatment, and of these eight, five had no fever within forty-eight hours. One patient, an adult, continued to have fever for six days after treatment was started, the longest in this series. The response in children was definitely more rapid than in adults. All of the children had normal temperatures in forty-eight hours or less except two, and both of these were afebrile in less than seventy-two hours. The average febrile days in children after treatment was started was 2.3 in contrast to four in the adults. Serial stool cultures were made in four of the five patients showing *Salmonella typhosa* in the feces. Stool cultures were reported as negative in an average of 4.25 days, the range being from two to nine days.

One patient expired suddenly on the fourth hospital day. This young woman had been given chloromycetin for two days prior to admission, and this therapy was continued in the hospital. On the second hospital day (the fourth day of chloromycetin therapy) her temperature had returned to normal, and she was greatly improved. After two days of normal temperatures and continued improvement, she expired suddenly. Complete necropsy, performed five hours after death, showed evidence of healing typhoid fever, but no cause for her death could be demonstrated.

RELAPSES MAY OCCUR

Two of the chloromycetin treated patients suffered relapses 16 and 34 days after discharge from the hospital. During their initial hospitalization both had a prompt clinical improvement with eradication of the typhoid organisms from the stools in two and six days after therapy was begun. In the relapse, the clinical response to the second course of chloromycetin was relatively prompt, both having normal temperatures in less than four days. However, a con-

siderably longer period of time elapsed, sixteen and twelve days respectively, before the typhoid organisms could be eradicated from the stools.

For contrast, results of the previous twelve consecutive, untreated patients with typhoid fever admitted to University and Children's Hospitals are presented. This control group was comparable in age and sex distribution to the group receiving chloromycetin. After the fourteenth day of illness (the same day that chloromycetin was started in the treated group), the control patients had a febrile course in the hospital that ranged from a minimum of six days to a maximum of twenty-two with an average of 13.5 days. This is in distinct contrast to the treated patients in whom the average febrile days were 3.16, less than one-fourth that of the control group. Eleven of the 12 control patients had stool cultures taken on admission that showed the presence of *Salmonella typhosa.* After the fourteenth day of illness, 21.6 days on an average were required to obtain cultures free of the typhoid organisms, more than five times as long as in the treated patients (4.25).

There were two relapses in both the control and treated groups. The recurrent febrile period in the controls was fifteen and sixteen days, while in the treated patients fever was present in each for less than four days after a second course of chloromycetin was administered.

The following case histories have been selected to illustrate: (1) The average response to chloromycetin treatment of typhoid fever; (2) failure of aureomycin therapy; and (3) the results obtained in the treatment of relapses.

CASE REPORTS

Case 1. J. L., a 42-year-old white housewife, was admitted to University Hospital, August 22, 1949. She had been in good health until five days before admission when she was suddenly seized by severe sharp pains in the lower abdomen that radiated to the back. There were no attendant gastrointestinal symptoms at that time. The pains were partially relieved by lying down, and were present intermittently until admission. Two days before admission she began to have shaking chills, and her temperature rose to 103°F. At the same time she became nauseated and vomited a dark brown material on several occasions, following which she was unable to retain any food or fluids. There was no diarrhea or other change in the feces. Because of the persistent pain and tenderness over the lower abdomen, she was admitted to the surgical service. Examination revealed a well-developed, well-nourished woman complaining of pains in the abdomen. Except for evidence of dehydration, significant physical findings were confined to the abdomen where diffuse tenderness and moderate spasm were noted over the lower portion. The edge of the liver was palpated about eight centimeters below the right costal margin. No masses or other solid organs could be felt. Rose spots were not present.

Blood cultures drawn on the first and third hospital days showed the presence of *Salmonella typhosa* after ninety-six hours incubation. On the third hospital day, the typhoid O aggultination was positive in a dilution of 1:80 and H was negative. During the period of observation, the patient's complaints persisted and her general condition remained unchanged. Her course was characterized by high spiking fever occurring in afternoon and evening, at which time she became stuporous and disoriented. On the fifth day the patient was transferred to the Contagious Disease service. Chloromycetin therapy was started immediately with an initial dose of 3.0 grams. (approximately 50 milligrams per kilogram of body weight) and maintained at 0.25 gram every two hours. In less than seventy-two hours her body temperature had returned to normal and she had almost complete relief of her subjective complaints. Then, she was given chloromycetin 0.25 gram every four hours for six days. Although she had several stool cultures that showed *Salmonella typhosa* while under treatment, she was discharged on the sixteenth hospital day after three consecutive stool and urine cultures failed to show the presence of typhoid organisms.

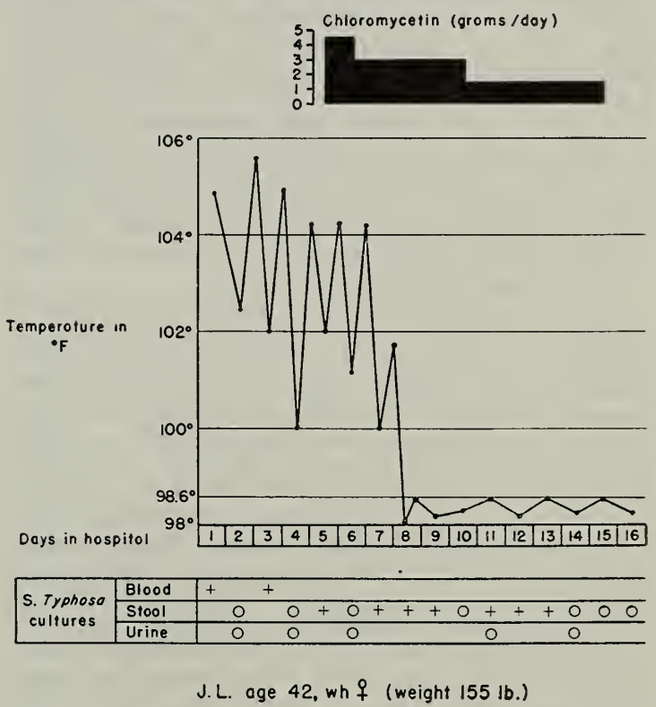


Figure 1. Hospital course in Case 1. The prompt clinical improvement of this patient resulting from chloromycetin (Chloramphenicol) therapy is representative of the average responses of all patients in this series.

Comments: Because this patient's complaints were referrable to the abdomen, she was admitted to the surgical service. The relatively sudden onset of severe abdominal pain ushering in typhoid fever is unusual. However the possibility of typhoid fever was considered by the attending surgeon, and blood and stool cultures and typhoid agglutination tests were made. The diagnosis was definitely established on the fifth hospital day by means of the blood culture, and chloromycetin was then started. The institution of therapy was followed by prompt defervescence and relief of subjective complaints. Her course is representative of the average clinical response of all patients in this series who received chloromycetin treatment, except for the delay in the eradication of the *Salmonella typhosa* from the stools.

* * *

Case 2. V. B., a six-year-old white girl, was admitted to Children's Hospital on February 24, 1949. She had been well until eight days before

admission at which time she became unusually tired and complained of generalized aching. She ate poorly, and her mother noticed that her skin felt hot. On the second day of her illness she developed a hacking, non-productive cough. At this time her temperature was recorded at 103°F., and sulfonamide therapy was instituted by the family physician. She had frequent chills, and her fever continued between 103° and 105°F. On the third day of her illness she began to vomit, and on the fifth day she passed several loose green stools. Because of her failure to improve at home, she was admitted to Children's Hospital for diagnosis and treatment.

Examination revealed a poorly developed, poorly nourished, dehydrated child who appeared acutely ill. The temperature was 103.2°F., pulse 132 and respirations 40. Pertinent physical findings were limited to the chest and abdomen. Percussion of the chest revealed dullness over the right lower lobe posteriorly. Fine crackling rales were scattered diffusely throughout both lung fields anteriorly and posteriorly, most prominent in the right lower lobe. The abdomen was distended and tympanitic without tenderness or rigidity. The spleen and liver were not palpably enlarged.

Blood and stool cultures taken at the time of admission showed the presence of *Salmonella typhosa*. A diagnosis of typhoid fever was made on this basis. Since chloromycetin was not available for general use at the time, this patient was treated with aureomycin. Beginning on her third hospital day, she was given 0.25 gram of aureomycin orally four times a day for a period of eight days. Her temperature remained spiking in character, and blood cultures showed the continued presence of *Salmonella typhosa* on two occasions. Then, the dose of aureomycin was increased to 0.50 gram four times a day and continued for a period of nine days. Although this was more than twice the usual recommended dosage of aureomycin, there was no change in her clinical course. Also it is of interest to note that there were no signs of toxicity. On the twenty-fifth hospital day she became afebrile for the first time and was discharged five days later.

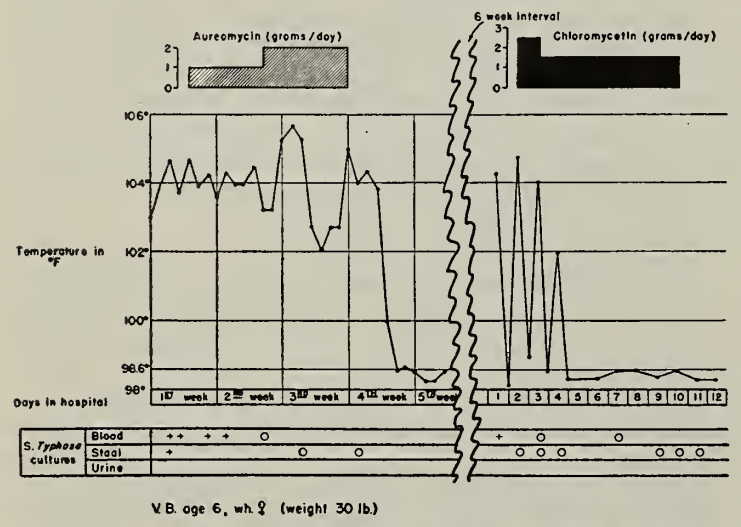


Figure 2. Hospital course and pertinent data in Case 2. This child received intensive treatment with aureomycin without any demonstrable alteration in the course of the disease. In contrast, very rapid improvement followed the chloromycetin (Chloramphenicol) treatment of the relapse.

For the ensuing four weeks she remained well. One week prior to her second admission she began to eat poorly, became listless and had frequent shaking chills. Her temperature varied from 100° to 103°F. Two days before her second hospitalization she began to have three to four loose stools per day. A diagnosis of recurrent typhoid fever was made, and she was readmitted on May 3, 1949, for treatment.

On admission her temperature was 104°F. Examination again revealed pulmonary changes compatible with a bronchopneumonia. The liver was palpated three centimeters below the right costal margin. There were no other abnormal findings. The blood culture taken at the time of admission showed the presence of *Salmonella typhosa* after forty-eight hours' incubation. Then, she was given an initial dose of 0.75 gram of chloromycetin. Subsequently, she was given a maintenance dose of 0.25 gram every four hours for eight days. There was rapid subjective improvement and her temperature returned to normal in forty-eight hours, remaining normal during the remainder of her hospital stay.

Comments: Although this child received massive doses of aureomycin, it apparently did not exert any beneficial influence upon the course of her disease, since her fever continued until the twenty-fifth hospital day. In very distinct contrast was the course of the relapse when treated with chloromycetin. She had rapid subjective improvement, her fever was gone in less than two days, and *Salmonella typhosa* were promptly eradicated from the body. In passing, it is of interest to note that such a large dose of aureomycin as 2 grams per day did not result in any toxic manifestations in a child weighing only thirty pounds.

* * *

Case 3. P. H., a 33-year-old white male laborer, was admitted to University Hospital on August 10, 1949. He had been well until eleven days before admission when he noticed gradual development of headache, malaise and easy fatigability. Six days before admission he began to have chills, associated with increasing fever. He had anorexia but no nausea or vomiting. Mild diarrhea began five days before admission with four or five loose stools per day. The stools were not bloody or tarry. The water supply at his home was from a shallow untested well. Examination revealed a well-developed, fairly well-nourished white male. The skin and oral mucosa showed evidence of dehydration, and the odor to his breath was fetid. The abdomen was essentially normal except for mild diffuse tenderness on palpation. A few rose spots were scattered over the abdomen and lower back. No other abnormal findings were noted.

Repeated blood and urine cultures were negative for *Salmonella typhosa*. Stool culture taken on admission was negative, but a stool specimen taken on the third hospital day showed the presence of *Salmonella typhosa* after forty-eight hours' incubation. He was then given 3.0 grams of chloromycetin (approximately 50 milligrams per kilogram of body weight) as an initial dose and then maintained at 0.25 gram every two hours. His temperature returned to normal in seventy-two hours with complete relief of subjective complaints except for weakness. Thereafter he was given 0.25 gm. of chloromycetin every four hours for the remaining five days in the hospital. After three consecutive daily stool and urine cultures failed to show the presence of *Salmonella typhosa* he was discharged from the hospital.

The patient returned to his home, and after two weeks of rest, he resumed his usual occupation which he was able to perform without undue fatigue. On September 24, 1949, he began to

notice increasing fever, especially in the evening, associated with malaise, generalized aching and a few loose stools. His illness became steadily more incapacitating and diarrhea increased to six to nine watery stools per day. Although anorexia was marked, he was able to take large amounts of fluid each day. About two days before admission he developed a productive cough. He was readmitted on October 7, 1949, thirty-four days after his release from the hospital. Examination on admission revealed a well-developed, underweight white male who appeared acutely ill. His face and neck were quite flushed, and rose spots were unusually numerous

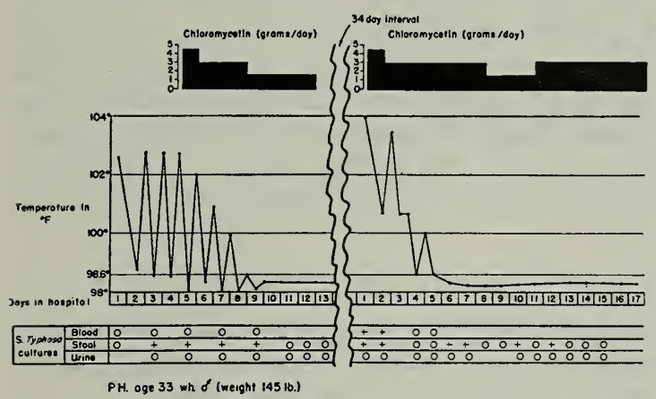


Figure 3. Hospital course in Case 3. During the patient's first hospitalization for typhoid fever he had a prompt clinical recovery attributable to his chloromycetin (Chloramphenicol) treatment. It is of interest to note that in his relapse his response was amost as rapid although a considerably longer period of time was required for the eradication of the Salmonella typhosa from the stools.

over the chest, abdomen and back. The pulse showed a relative bradycardia (92 per minute when his temperature was 104.5°F.), and it was dicrotic. The liver was palpated four centimeters below the right costal margin, and the tip of the spleen was palpable. No other abnormal findings were noted.

Blood and stool cultures taken on admission showed the presence of *Salmonella typhosa*. Immediately upon readmission to the hospital, he was given 3 grams of chloromycetin and then 0.25 gram every two hours. His temperature fell from 104.5°F to normal within ninety-six hours, accompanied by complete relief from all subjective complaints. Although his clinical response to chloromycetin was almost as prompt as it was during the first time, he continued to have stool cultures which contained *Salmonella typhosa* intermittently for twelve days.

Comment: This patient was only moderately ill with typhoid fever on his first admission. Chloromycetin therapy resulted in rapid improvement and elimination of *Salmonella typhosa* from the stools. However, the relapse would indicate that in spite of eight days of chloromycetin therapy in this patient it was not adequate to completely eradicate *Salmonella typhosa* from his body. On readmission he was much more acutely ill than during the first hospital stay. His clinical response to chloromycetin was almost as rapid as during his first course of treatment. However, it will be noted that a considerably longer period of treatment with relatively larger doses was required to eliminate the causative organisms from the stools during the relapse.

DISCUSSION

It appears from the data presented that chloromycetin (Chloramphenicol) is quite effective in the treatment of typhoid fever. The patients so treated experienced rapid subjective improvement as well as a prompt defervescence. The average number of days of fever in this group was 3.16. In the few whose temperatures remained elevated for more than three days, a definitive subjective improvement was noted by the end of forty-eight hours and before the fever showed evidence of subsiding. In addition to the prompt relief of symptoms and the defervescence, the *Salmonella typhosa* were much more rapidly eradicated from the blood and/or the stools than in the untreated, and the period of hospitalization was considerably shortened.

The data of this series confirm the favorable results first reported by Woodward, et al.,[2] in the treatment of typhoid fever with chloromycetin. Essentially similar results from a series of twenty-one patients were published later by Woodward.[3] Recently, Collins and Finland[4] reported on the chloromycetin treatment of four patients with typhoid fever. Their results were not as impressive as those of previous reports, either as to clinical improvement or to the eradication of *Salmonella typhosa* from the blood or stools. In their experience the difference between the effects of chloromycetin and aureomycin is not as striking as others have reported. However, for the patients herein reported the subjective improvement and prompt defervescence was dramatic. The conversion of positive cultures to negative was usually prompt. Certainly the results were in very distinct contrast to the prior series of patients who did not have the benefit of chloromycetin treatment.

Woodward[2, 3] reports that certain serious complications, viz., hemorrhage and intestinal perforation, may occur during or after treatment although possibly in decreased incidence. Hemorrhage or perforation did not occur in our series and no other complications were present. However, one death occurred which could not be ascribed to either the typhoid fever or the chloromycetin.

Early data pertaining to the use of chloromycetin have been characterized by the absence of toxic reactions. Woodward[3] states that "significant toxic effects have not been observed." However, Collins and Finland[4] report one patient with vertigo, heartburn, sour taste and anorexia and another with nausea, vomiting, glossitis and cheilitis that might be attributed, in part, to this antibiotic. However, the evaluation of anorexia, nausea, vomiting, or diarrhea as a toxic manifestation due to chloromycetin is particularly difficult in this instance because they are frequent occurrences in the course of typhoid fever. In the present series there were no apparent untoward effects resulting from the use of this antibiotic.

Aureomycin, in the treatment of typhoid fever,

has produced only equivocal results.[5] In the one patient in this series who was treated with aureomycin, there was no demonstrable alteration from the usual course of untreated typhoid fever. However, when the relapse occurred, there was very prompt clinical improvement and defervescence as the result of chloromycetin therapy. These results are in agreement with those of Woodward[3] who in comparing aureomycin and chloromycetin concludes that the latter is definitely the drug of choice in the treatment of typhoid fever.

Published data indicate that, while the clinical response of typhoid fever to chloromycetin is striking, *Salmonella typhosa* may persist in the body in some instances. Thus, relapses may occur in spite of apparently adequate treatment. In this series there were two patients who, following eight and ten days of chloromycetin therapy, had bacteriologically confirmed relapses. Although both responded promptly to a second course of chloromycetin, *Salmonella typhosa* persisted in the stools for a much longer period than during the initial hospitalization even though the antibiotic was administered for a longer time. According to Smadel, Woodward, and Bailey[6] there is a definite relationship between the duration of therapy and the incidence of relapses. To avoid possible relapses, they believe that all patients should be treated for a minimum of nine days, but that little is to be gained in continuing therapy beyond fourteen days. It would appear that considerable further study and experience will be necessary to determine the optimum dosage for chloromycetin in the treatment of typhoid fever.

CONCLUSION

1. Chloromycetin appears to be effective in the treatment of typhoid fever, affecting relatively prompt defervescence and relief of subjective complaints. In some patients there is a lag between the clinical improvement and the eradication of *Salmonella typhosa* from the body.

2. Even with apparently adequate chloromycetin therapy, relapse may occur. In the present series two patients had relapses, both of whom had prompt clinical response to a second course.

3. In relapse treated by chloromycetin a longer period was required for the eradication of *Salmonella typhosa* from the stools than during the initial attack.

4. None of the patients showed any evidence of toxic reaction to chloromycetin.

5. In the one patient treated with aureomycin there was no demonstrable influence upon the course of the disease.

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KEEPING UP WITH MEDICINE

• IN the study of human beings and their reactions, one must always consider the whole individual personality. The good physician has always found it necessary to concern himself not only with the disease pattern of his patient but also with the personality of the patient himself.

* * *

• THE age-old theory that women are less criminal than men has been shattered. Her transgressions are masked while showing a predilection for and an adeptness at deceit.

* * *

• IN many places throughout history cross-eye was associated with "the evil" and black magic and its victims were often blamed for outbreaks of pestilence, famine, fits among children, miscarriages, sickness of domestic animals, and other afflictions.

* * *

• IT is suggested that one full year of sterility after contraconception practices have been discontinued should be a matter of concern for the family physician since recent surveys show 90 per cent of planned pregnancies occurred within that time.

* * *

• STUDIES of the cervical mucus is proving to be helpful in investigating sterility, fertility, and other aspects of the reproduction process.

* * *

• THE ever-increasing mechanization of our common tasks and the ease of transportation have lessened the ordinary physical activity to the point that the natural demands of the human body for sternous movements are not being met in the majority of our people.

* * *

• THE preserving action of common salt on meat seems to depend upon five factors viz: dehydration, the direct effect of the chloride ion, removal of oxygen from the medium, sensitization of micro-organisms to carbon-dioxide and the interefence with the rapid action of proteolytic enzymes.

* * *

• CARDIOVASCULAR diseases accounted for 44 per cent of all deaths in the United States in 1948. If you are past 65 the chances are 55 out of 100 they will get you.—J. F.

The Management of Acute Cholecystitis

CHARLES E. HOLZER, JR., M. D.

THE policy of early operation in acute cholecystitis, though it has been in the recent past the subject of much controversy, has now been fairly generally adopted, at least in principle if not in practice. There is very little argument concerning the advisability of removing or draining the acutely obstructed gallbladder as soon as possible after the onset of the attack. A review of the literature shows that in the past two decades the debate over the management of acute cholecystitis went through much the same stages as the earlier discussions concerning the management of acute appendicitis. Around the year 1900 there were surgeons who advocated appendectomy early in the disease, and those who preferred to delay the operation until drainage became necessary or until the attack had subsided and appendectomy could be done as an elective procedure.

ONLY ACCEPTED TREATMENT

Now of course the only accepted treatment of acute appendicitis is appendectomy as early in the course of the disease as possible, usually as soon as the diagnosis is made or even suspected. The same principle with minor variations can and should be applied to the management of acute cholecystitis. Much of the controversy over the subject was caused by confusion over the definition of "early operation," some writers using the term to mean "operation soon after admission to the hospital" and others meaning "operation early in the course of the attack." It is of historical interest to note that Finney, Heuer, Judd, Eliason, and Zinninger were among those strongly advocating early surgical management, the opposing viewpoint being taken by Behrend, Deaver, E. A. Graham, Lewis, and Lahey.

While very few surgeons would now follow any other course than early surgical interference in acute cholecystitis, there still exists the concept that "the acute gallbladder attack" is a condition which can be managed at home, and that the patient need be sent to the hospital only if the signs and symptoms do not subside in a few days. This has resulted from the previous controversies on the subject, and it is only by constant repetition of the doctrine that acute cholecystitis is a surgical emergency, every bit as urgent as acute appendicitis, that the mortality and morbidity of acute cholecystitis can be diminished.

SURGICAL EMERGENCY

The purpose of this paper is to re-emphasize this teaching, to review the factors that influence the mortality and morbidity resulting from acute cholecystitis, to analyze our experience with the condition, and to try to illustrate conclusively the validity of the above stated principle.

Acute cholecystitis is almost always secondary to cholelithiasis. The incidence of acute cholecystitis in patients with gallstones, though no accurate determination can be made is estimated to be rather high. Heuer has put this probable figure as high as 20 per cent. If this is true, it is a strong argument for the removal of any gallbladder containing stones, particularly in a younger person who would thereby be saved the one to five chance of developing acute cholecystitis. Since in experienced hands cholecystectomy in the absence of complications such as acute cholecystitis, common duct stone, or pancreatitis, carries a mortality of less than one per cent, there is no excuse for a physician's allowing a person to retain such dangerous possessions as gallstones year after year, especially if that patient is having any related symptoms. When one adds to the hazard of acute cholecystitis the chance of development of cancer of the gallbladder, common duct stone, or acute pancreatitis, all of which are directly related to gallstone disease, there is no question as to the justification of the above condemnation. Every physician knows of patients who have had gallstones for many years without any symptoms or complications, yet it would seem far better to remove a number of gallbladders needlessly than to chance the death of any of these patients from a complication of cholelithiasis provided the gallbladder can be removed safely in that particular patient.

Acute cholecystitis is primarily an obstructive phenomenon. The usual chain of events is first the impaction of a stone in the ampulla or cystic duct producing a complete obstruction to the outflow of bile. Edema and distention of the gallbladder follow. The blood supply is impaired or occluded by pressure of the distended and edematous tissues. This is the typical picture in the first forty-eight hours. Subsequently the course may vary. The stone may become dis-

Presented before the Athens County Medical Society on September 13, 1949.

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lodged allowing the gallbladder to empty, in which event there will be residual fibrosis, and after repeated such attacks a small, fibrotic viscus will result. If the obstruction persists complete occlusion of the arterial blood supply may supervene resulting in gangrene and perforation, in which case either bile peritonitis or a pericholecystic abscess will ensue, depending upon the rapidity of the changes and the ability of the omentum to wall off the gallbladder. Bacterial invasion of the obstructed gallbladder may occur, resulting either in suppurative cholecystitis or in empyema of the gallbladder. Sometimes the inflammation may subside in spite of persistent obstruction of the cystic duct producing a so-called hydrops of the gallbladder. In all of the 50 operated cases in our series obstruction of the gallbladder existed. Twelve cases showed patchy or extensive gangrene, four had pericholecystic abscesses, two had free perforations with bile peritonitis, one had empyema, and one had hydrops of the gallbladder.

FAMILIAR SYMPTOMS AND SIGNS

The symptoms and signs of acute cholecystitis are of course familiar. The attack usually begins with severe colicky pain in the right upper quadrant or epigastrium radiating around the right costal margin to the tip of the right scapula. Vomiting is a frequent occurrence and the pain is often relieved afterward. A persistent ache and tenderness in the right upper quadrant follow. Fever and sometimes a chill may occur. The leukocyte count is elevated to a variable degree depending on the extent of infection and necrosis. Physical examination reveals tenderness in the right upper quadrant associated with muscular rigidity. A tender mass is usually felt. A sign valuable in differentiating the acutely inflamed gallbladder from other pathological conditions in the right upper quadrant is the severe exacerbation of pain on deep inspiration while the examiner presses the abdominal wall inward against the gallbladder. The pain results from irritation of peritoneal nerve endings as the fundus of the gallbladder descends against the adjacent parietal peritoneum. This sign is absent in acute pancreatitis, acute passive congestion of the liver, ruptured peptic ulcer and other conditions which might be confused with acute cholecystitis. A mass can usually be felt if the examiner is able to overcome the muscle spasm by using a patient, gentle touch. Palpation is aided by the left hand pushing forward from behind in the right flank. Masses were described in 40 of our 58 cases. The mass is formed by the dome of the distended gallbladder usually surrounded by edematous omentum.

In this clinic once the diagnosis of acute cholecystitis has been made it is the policy to operate as soon as it is feasible, the general condition of the patient, the duration of the disease, and the presence of complications of gallstone disease all being taken into consideration. Considerable time may elapse between admission to the hospital and the operation, but in only exceptional instances is a conservative regime deliberately adopted. A careful clinical and laboratory study is made not only to confirm the diagnosis and to detect complications such as pancreatitis, or cholesdocholithiasis, but also to evaluate the fitness of the patient for immediate or subsequent operation and to determine the conditions which must be corrected before operation can be safely attempted.

PREPARATION FOR SURGERY

As soon as the situation can properly be evaluated such measures as are indicated are taken to prepare the patient for operation. Fluid balance is restored, gastric suction may be instituted to relieve vomiting and abdominal distention, an enema may be given, antibiotic therapy with penicillin may be begun if the indications are that infection is present, diabetes is treated, cardiac failure is remedied and the patient is kept as comfortable as possible preferably with demerol, as this drug has been shown to have a spasmolytic effect on smooth muscle as well as its analgesic action.

The decision as to when to operate then must be made. There is always sufficient time for a careful initial evaluation of the patient and this evaluation should never be by-passed because of an urgency to bring a patient to operation early. If the attack is of a few hours duration and the patient's condition is good the operation should be carried out immediately. Cholecystectomy can usually be done safely. If the disease is of longer duration it is ordinarily necessary to take a longer time in the preparation of the patient. Occasionally one is forced into operating on a patient before preparation is deemed complete. The temperature, pulse, leukocyte count, and the status of the abdominal findings are of some importance in determining whether or not it is safe to procrastinate further. Rapid enlargement of the mass accompanied by an increase in the fever and the leukocyte count urge immediate surgical intervention. It must be kept in mind constantly however that the vital signs are notoriously unreliable in indicating the true state of affairs with the acutely obstructed gallbladder. The surgeon must be on his guard against being lulled into a false sense of security by a subsiding temperature and leukocyte count and a general improvement in the condition of the patient. The operation should be done at the earliest auspicious moment. Thirty-three of the 50 patients herein discussed were operated on within 48 hours of their admission to the hospital. Since one-half of the cases were admitted to the hospital within 48 hours of the onset of their attack

it is clear that the policy of early operation was carried out with consistency.

CHOICE OF OPERATION

The choice of operation is a matter of great importance. Cholecystectomy is the procedure of choice and should be carried out if possible without increasing too greatly the risk to the patient. There are certain instances in which cholecystostomy is indicated not only as a "second best" procedure after cholecystectomy has been attempted and found hazardous, but as the procedure of choice. The use of cholecystostomy varies a great deal in the reported series of cases. Marshall[1] in the Lahey Clinic reports 74 cases of acute cholecystitis in only one of which was cholecystostomy carried out, the remaining patients having cholecystectomies. Glenn[2] reports an incidence of 12.6 per cent cholecystostomies in 527 patients operated on for acute cholecystitis at the New York Hospital. Eliason[3] in 135 cases reported 68 per cent who had cholecystostomies. In our own series 30 patients had cholecystectomy and 20 had cholecystostomy, an incidence of 40 per cent for cholecystostomy. A comparison of the incidence of cholecystostomy means very little in determining the operation to be used in acute cholecystitis. Certainly the cases must vary considerably in the series reported, depending on the economic status of patients treated, the location of the clinic, and the type of hospital. In our series cholecystostomy was done 20 times. Only two of these patients were under 50 and ten were over 70. Only seven of them were seen in less than 48 hours after the onset of the attack. Four patients had pericholecystic abscesses, one had acute pancreatitis and cholangitis, one had severe diabetes, and four had serious cardiac disorders. Our indications for cholecystostomy are clearly expressed in these statistics. Rarely should cholecystectomy be attempted in a patient over 70 years of age. Cholecystostomy serves exactly the same purpose with regard to the immediate danger of the disease, carries a much lower risk, and if performed properly, produces as good postoperative results in the immediate future.

The follow-up results in all of our patients with cholecystostomy have been quite satisfactory. In almost all patients over 70 in our practice cholecystostomy is elected and carried out as a planned procedure under local anesthesia through a short subcostal incision. Care is taken to see that all stones are removed. The mucosa is curetted thoroughly and the gallbladder is irrigated to remove all stones and debris. A large rubber tube is sewn into the fundus and several Penrose drains are distributed around the gallbladder. Bile drainage usually continues for 10 days to two weeks in gradually diminishing amounts. The tube can be removed in 10 to 14 days. Following this the biliary fistula closes in a few weeks. We have found the results of cholecystostomy to be quite satisfactory and do not hesitate to employ it at any time to avoid undue risk to the life and welfare of the patient. The surgeon should not hesitate to change his mode of attack to cholecystostomy either when he encounters a pericholecystic abscess, acute pancreatitis, or too much edema and inflammation about the hepatic porta to make cholecystectomy safe, or in the event of some sudden change for the worse in the patient's condition.

Choledochostomy should be avoided if at all possible in acute cholecystitis. The edema and inflammation of the peritoneum and areolar tissue around the common duct make exposure and visualization of all the structures difficult and often impossible. Many times it is preferable even if common duct obstruction is present to perform a cholecystostomy and plan to explore the duct later and remove the gallbladder.

TECHNIQUE

Little need be said about the technique of operation for acute cholecystitis. If cholecystectomy is done the greatest care must be taken to control bleeding from the gallbladder fossa. The cystic duct and artery should be visualized, isolated, and individually ligated. The common duct should be identified before any structure is clamped, ligated or divided or if because of edema and inflammation the structures cannot be identified the gallbladder should be removed from the fundus downward until the cystic duct can be isolated. The danger of operative injury to the common duct is especially great in these cases. It is our practice to drain all cases. Two to four Penrose drains are placed down to Morrison's pouch and brought out through a stab wound separate from the working incision. Although an occasional case can be closed safely without drainage we are frank to admit that we do not feel capable of selecting these cases. One is often surprised at the amount of drainage of bile and serosanguineous fluid following an apparently perfect operation in a seemingly dry field. A second argument for routine drainage is that occasionally the ligature on the cystic duct may slip or cut through allowing a free flow of bile from the duct. If drainage has been provided this complication is of little or no consequence, but if the abdomen has been closed without drainage, a fatality may very well result. Drainage of the pouch of Morrison results in little or no increase in morbidity or discomfort and may be life-saving in certain circumstances, as has been pointed out. The drains should if possible never be brought out through the working incision but through a separate stab wound. This procedure avoids contamination of the larger incision, it places

the drainage area at a distance in case the wound has to be re-entered for some reason, and in the event that a biliary, duodenal or pancreatic fistula should develop, the working incision will not be exposed to digestive enzymes causing disruption of the entire wound.

ANESTHESIA PREFERENCES

The anesthetic used depends on the condition of the patient, the agents available, and the skill of the the anesthetist. If cholecystostomy is to be done as the procedure of choice, local infiltration and regional block of the abdominal wall with procaine affords adequate anesthesia and relaxation with practically no risk. For cholecystectomy may be used either spinal anesthesia with procaine or pontocaine, or endotracheal inhalation anesthesia using cyclopropane, ether, or a combination of gases supplemented with curare if necessary for relaxation. The trend in our clinic has been towards endotracheal inhalation anesthesia for upper abdominal surgery whereas formerly spinal anesthesia was preferred. The development of better techniques and more skill in handling endotracheal anesthesia accounts for this trend.

It is difficult to avoid some discomfort to the patient when operating in the upper abdomen under spinal anesthesia because of the necessity of placing traction on the costal margins, the diaphragms and occasionally on the esophagus. This disadvantage can be overcome by using small doses of sodium pentothal. However in the hands of a skilled anesthetist endotracheal inhalation anesthesia has most of the advantages and none of the disadvantages of spinal anesthesia and is our choice in these cases.

POSTOPERATIVE CARE

The postoperative care after cholecystectomy or cholecystostomy for acute cholecystitis follows in general that for other intra-abdominal operations. Fluid balance is maintained by the parenteral route until oral feedings can be resumed. Vomiting and distention are managed by means of gastric suction. Antibiotic therapy with penicillin and occasionally streptomycin is used when indicated by evidence of extensive infection or perforation. Early postoperative ambulation is instituted with all patients who can tolerate it. The drains are removed in stages starting on the fourth or fifth day after the operation. The patients remain in the hospital from 10 to 15 days in the uncomplicated cases.

CASE RECORDS STUDIED

Fifty-eight case records covering a period of three years were studied in connection with this report. Several other cases were excluded because the findings were not clear-cut enough to place them in the category of acute obstructive cholecystitis. Fifty patients were operated with a total of three deaths. One of those patients was moribund on admission with a perforated gallbladder and generalized peritonitis, cholecystostomy being done as a last desperate measure. The second patient died suddenly at home on the thirtieth postoperative day presumably from a pulmonary embolus. The third death was in a 58-year-old woman who died of coronary artery occlusion and myocardial infarction on the ninth day after operation. A cholecystectomy had been done despite a past history of angina pectoris and hypertension. The electrocardiogram was normal. The advisability of performing cholecystectomy instead of cholecystostomy was discussed before operation and it was the opinion of the medical consultant that the cardiac damage did not make her an unreasonably bad risk for cholecystectomy. In retrospect it would seem that cholecystostomy should have been elected and might perhaps have been survived by the patient.

The operative mortality in this series of cases was therefore six per cent, which compares favorably with most other published statistics. We consider the results a favorable argument for the plan of management stated above when one considers that twelve of the patients operated or 24 per cent, were 70 years of age or over and that 50 per cent were not seen within 48 hours of the onset of the attack. There were no complications such as wound disruption, fistula formation, or infection in the wounds closed without drainage. Other complications were atelectasis—3 cases, pulmonary infarction —1 case, phlebothrombosis—2 cases, coronary occlusion—1 case, acute pancreatitis—1 case.

It is of interest to consider the eight cases in which a diagnosis of acute cholecystitis was made but in which for some reason operation was not carried out. Three of these patients were aged and had severe heart disease. A plan of watchful waiting resulted in subsidence of the signs and symptoms in less than 24 hours allowing the operation to be postponed until such time as it might become mandatory. Had the signs and symptoms of acute cholecystitis persisted, these patients would have had cholecystostomy despite the risk. Three patients refused operation largely because their pain had begun to subside. They recovered from the acute attack. One 38-year-old woman was treated conservatively because her acute attack started one day after a hysterectomy. She was treated expectantly and her symptoms abated. The last patient was a 48-year-old woman who was in a critical condition with jaundice, fever, and vomiting of several weeks' duration. While being prepared for common duct exploration she developed generalized peritonitis with shock and died in 48 hours. Autopsy revealed a perforated gallbladder with bile peritonitis, and a large stone completely obstructing the common duct. The fact that in seven patients the pathological proc-

ess apparently subsided without operation might seem to constitute an argument for the conservative management of acute cholecystitis. However, as it has been pointed out previously one is unable to predict in which cases this will occur. The surgeon is not justified in waiting for such an occurrence with the idea that operation may be done at any time, because the technical difficulties and risk to the patient's life are greatly increased when operation is delayed.

SUMMARY

The pathogenesis, clinical diagnosis, and management of acute obstructive cholecystitis have been discussed and a plan of management has been presented.

The result of the management according to this plan of 58 patients with acute cholecystitis is reported.

CONCLUSION

1. Acute cholecystitis is primarily an obstructive phenomenon usually of a progressive nature.

2. Conservative management of acute cholecystitis is hazardous, especially because of the unreliability of the clinical signs and symptoms as indicators of the course of the pathological processes involved.

3. Cholecystectomy within the first 72 hours of the onset of the disease is the treatment of choice.

4. When cholecystectomy is not feasible because of the poor condition of the patient or because of technical difficulties cholecystostomy produces good immediate results.

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Foreign Body of the Rectum and Colon

The motives from which foreign bodies are introduced into the rectum and colon fall into four groups: criminal assault, evil pranks, accidental impalement, and sexual perversion.

The objects found in the rectum and colon due to criminal assault and evil pranks are chiefly: olive bottles, whiskey glasses, electric light bulbs, vaseline bottles, various sorts of sticks and etc.[1, 2, 3, 4]

Accidental impalement occurs chiefly in rural districts and the foreign bodies are usually the handles of a hoe, rake, or pitchfork.

Sexual perversion is another form of introducing objects into the rectum and colon. A constant use of this procedure may result in injury to the perianal tissue, rectum, or perforation of the rectosigmoid. The seriousness, of course, depends upon the size, shape, and sharpness of the object plus the direction and force used in driving the foreign body into the anus and rectal canal. The removal of such foreign bodies depends upon their size and shape, and the ability to get access to the foreign body. Large bodies in the colon usually require a laparotomy.

The case I wish to present is unusual because of the size and shape of the object. It consisted of a vaginal douche tip measuring 5½ inches in length attached to a heavy rubber insulated electrical wire, 14 gauge, measuring 17 inches in length. The douche tip was bent upon the wire. The over-all length is 22½ inches.

REPORT OF CASE 7432 E

A young, well-nourished, white male, age 25, was first seen in the emergency room at St. Thomas Hospital, Akron, Ohio, with a complaint that he introduced an electrical wire into his rectum two days ago and was unable to remove it. No other history was obtainable as the patient refused to comment on the size, shape and length of the wire and motive of insertion. The patient was quite comfortable except that he could not sit down because of the wire protruding from the anus about one inch. Slight traction was applied to the wire and the patient complained of abdominal discomfort. Digital examination revealed only a long wire extending as high as the finger could reach.

The patient was then taken to surgery and under spinal anesthesia, a sigmoidoscope was passed with the wire through the scope in an attempt to find the proixmal end of the wire and dislodge the end. This was unsuccessful because the wire extended beyond the length of the sigmoidoscope. The patient was then prepared for a laparotomy and through a left rectus incision the abdomen was opened and explored. No perforations were found in the rectum, sigmoid, or colon. The foreign body was easily palpated in the mid-descending colon. The descending colon was opened just superior to the foreign body, cutting through the tinea for about three inches. The curved part of the object was removed through this opening.

The colon was closed with interrupted Lambert sutures of black silk and reinforced with interrupted black silk sutures. A piece of omentum was then sutured over this incision. The abdomen was closed in layers with no drainage. The patient received streptomycin and penicillin postoperatively. Convalescence was uneventful and he left the hospital on the eighth postoperative day. A history was later obtained revealing that the patient had been following such practices for the past year, deriving a satisfaction of his sexual demands.

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Innocuity of Protracted Oral Administration of Special Fermentation Concentrates of B_{12} as Demonstrated In a Patient With Acute Leukemia

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EXTENSIVE pharmacologic and toxicologic studies on B_{12} administration to human beings have not as yet appeared in the literature though the innocuity of the material would seem to be established, for the usual doses, by the presence of B_{12} in liver extracts and in animal proteins generally. The cobalt content of B_{12} is so small (4 per cent) that one would hardly anticipate any of the pharmacodynamic effects of that element though Barnard and Weitzner did observe skin flushing, diuresis[1] and muscle cramps after more than the usual dose.

It has not been determined whether these effects were due to impurities in their preparation. So far, the only untoward effect of relatively massive doses of oral B_{12} that has been observed in 200 patients receiving this material is an occasional acneform eruption which four patients considered to be casually connected with the medication. A heightened skin color or flush has also frequently appeared in patients receiving oral grades of B_{12} but this can hardly be classified as an untoward effect. In the vast majority of instances, administration of a fermentation product containing 6 micrograms/gram, in doses of forty grams per day, continuously for several weeks has been without incident. The majority of patients to whom this material was fed, were not seriously ill.

It was conceivable that a noxious agent would be borne with impunity by an individual in good health but that invidious qualities would be brought out on administration to a person in poor health. Thus, the senior author has seen blast crises produced by small doses of inorganic cobalt in acute leukemic patients.[2] The present report deals with an acute leukemic patient who has received a total of 30 **milligrams** of B_{12} over the past three months. It is presented only from the viewpoint of the apparent innocuity of the material when administered by mouth, though the case will be discussed also on the basis of interesting features of acute leukemia which it reflects.

Submitted April 26, 1950.

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CASE REPORT

W. L., a 64-year-old bakery worker developed what was thought to be an atypical or viral pneumonia early in December, 1949. He failed to respond to antibiotic therapy and fever and prostration failing to abate, a blood count was procured. This revealed a marked macrocytic anemia and normoblastosis along with a total leucocyte count of 1,800 of which 33 per cent were reported to be granulocytes and 22 per cent as unidentified cells. He was seen by the writers on December 14 when a sternal marrow aspiration was performed and revealed that 67 per cent of all nucleated forms were of the blast type. The spleen was palpable with its inferior border about midway between the costal margin and the umbilicus. He was hospitalized on December 16 because of progressive prostration, fever and pallor. On the basis of the marrow findings, the peripheral blood granulocyte hiatus, a strongly positive plasma polyphenol reaction and the moderate splenomegaly, a diagnosis of acute estrapenic leukoblastosis (acute leukemia) was made without qualification as to type. He was given 500 cc. of whole blood intravenously and 30 grams of reconstituted pooled irradiated (ultra-violet) human plasma fraction "44-66" subcutaneously* following which, myelocytes appeared in the peripheral smear and permitted the designation of the leucoblastosis as myeloid in type. The patient left the hospital on December 18, not sensibly benefitted by the infusions and a rapid dissolution was anticipated. On the day of discharge, he was started on a

* This fraction is prepared by precipitating all protein which is insoluble at 66 per cent ammonium sulfate saturation, after the gamma globulin has been removed by 44 per cent ammonium sulfate saturation; hence the designation as "44-66." The fraction recovered between these ammonium sulfate saturation percentages contains the plasma cholinesterase, a fraction which inhibits glycoprotein pseudoagglutination and also, apparently, the "myeloblast maturation" factor of Schwind.[3] We are indebted to Drs. Robert Pennell and Peter Masucci of the Medical Research Division, Sharp and Dohme, for this fraction. We have used it in other cases of acute leukemia to attempt to augment the diminished blood cholinesterase which we believe to be responsible for some of the morbid manifestations of acute leukemia.

dietary supplement of 20 grams of crude linseed oil emulsified in milk with Tween 80 and 10 grams of crude fermentation concentrates† four times daily.

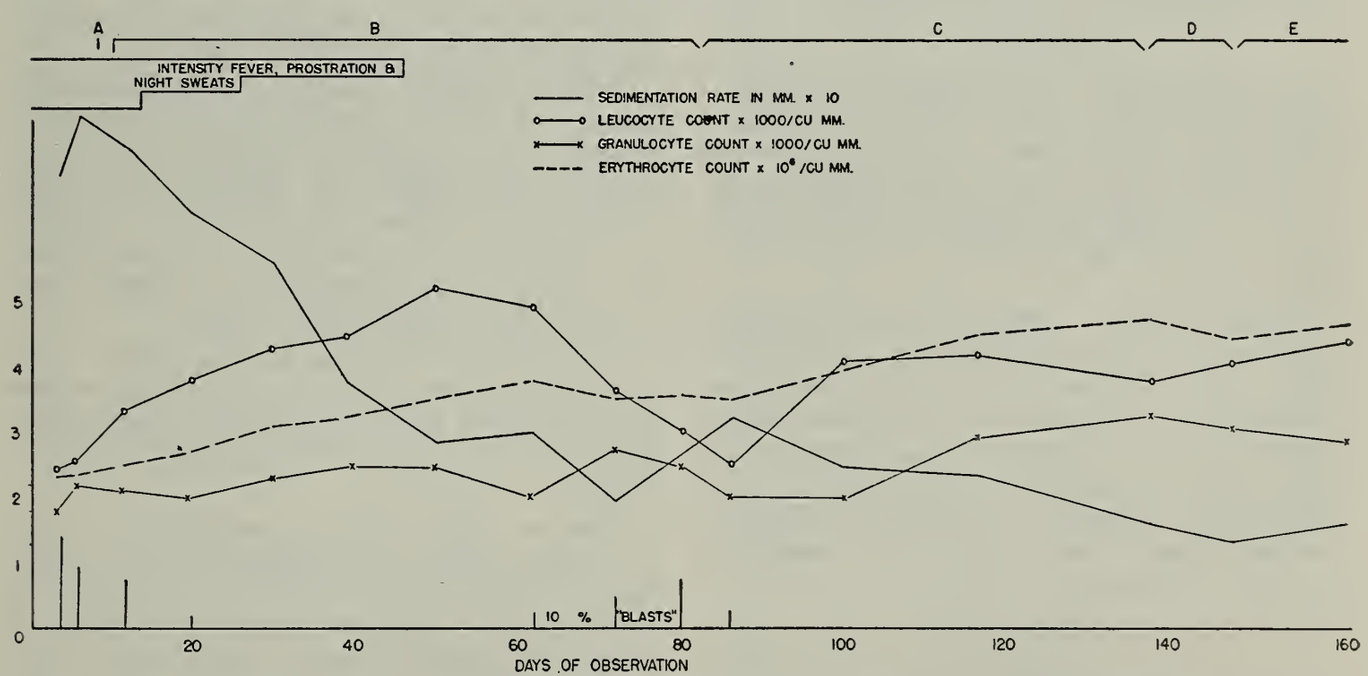
The patient's dissolution was not as rapid as was anticipated, somewhat to the embarrassment of the attending physicians who had summoned the children from a considerable distance. Over the next two weeks the patient's appetite returned and became voracious, the temperature underwent a lytic decline, the drenching sweats and pallor abated gradually and at the end of a month after discharge from the hospital, all symptoms except a persistent, but smaller spleen, had disappeared. The clinical change was concomitant with an improving hematologic status which is recorded throughout the course in Figure I. Initially, there was gradual fall in the elevated sedimentation rate and (not recorded) a lowering of the plasma polyphenol content. Except for a moderate anemia, this hematologic normalization was most apparent at the end of the second month of the treatment period. A definite hematologic relapse is indicated by the graph at the beginning of the third month though the patient's physical condition remained superb; he walked two miles twice a day and it was only for forensic reasons that we refused permission for him to return to work. However, he had gained 32 pounds since the onset of his illness. Careful evaluation failed to show this to be due either to edema or tumor; the spleen, in fact, was still shrinking. The weight gain was apparently flesh and so the linseed oil-Tween 80 emulsion(representing almost one thousand calories per day) was discontinued and the special fermentation concentrate changed to one that contained 8 micrograms/gram so that the daily dose was 320 micrograms of B_{12}. At the present time there is essential normality both of the clinical and hematologic aspects of the case.

† This product and related materials were generously supplied by Charles Pfizer and Company, Brooklyn, N. Y.

DISCUSSION

The potential remissibility of acute leukemia has been a previous theme[4] and the concept of the nature of acute leukemia as a decompensatory atopic-exudative reaction, mandating such a potentiality for remission, has been repeatedly elaborated.[5] From that standpoint, we see nothing remarkable about the course of this patient's illness nor do we attribute to the high dosage of B_{12} other than a supportive role, if anything, in the evolution of this particular case. If it is to be discussed as one of acute leukemia showing more than a single (hematologic) remission, then it should be remarked that we are in possession of a case history which exhibited one more remission than did the present case; a total of three distinct simultan-

FIGURE I



At A the blood-plasma concentrate transfusion was administered. During the period B the diet was supplemented by 80 grams of linseed oil with Tween 80 and 40 grams of concentrate from an antibiotic producing streptomyces strain, daily. The concentrate was known to contain 6 micrograms of B_{12} activity and 225 units of antibiotic (as streptomycin activity) per gram during the early portion of the B interval; during the latter portion ,while the B_{12} unitage remained constant, there is no assay of antibiotic potency which may not have been present. There was hematologic, though no clinical deterioration during this latter portion of the B period. During the C period, a concentrate containing 8 micrograms of B_{12} and 300 units of antibiotic per gram was administered daily in 40 gram dosage. At D this was replaced by a concentrate from a streptomyces strain which was an antibiotic non-producer, in doses corresponding to 550 micrograms of B_{12} daily. D was terminated at the end of ten days because of indications of clinical, though none of hematologic deterioration. During E, which is still extant, 10 grams of the same material used during interval C, along with 750 milligrams of terramycin (from streptomyces rimosus) is given daily. During this last period there has been rapid regression of residual splenomegaly and the condition is evidently normal. There are two bowel movements a day which show a gram positive bacillary character. Normoblasts, always present previously, have not been seen since the 50th day of illness, even during the blast crisis of 60-80th day. The latter point stresses the lack of corcordance throughout between clinical and peripheral hematologic findings.

eous hematologic and clinical remissions and relapses. From this standpoint, as well as several others, we regard the present situation in the treatment of acute leukemia to be exactly comparable to that existing for Addisonian anemia just prior to the announcement of liver therapy by Minot and Murphy[6] but consequent to the excellent studies of Mosenthal[7] and of Gibson and Howard[8] who used their own ideas of supportive regimes.

On the basis of our concept of the nature of the acute leukoblastotic process, whereby the blast is regarded as a result, rather than as a cause of the disease, we eschew all forms of myelosuppressive therapy and though our experience has been as universally bad as that of any other observer, our durations appear to be over twice as long and we are more optimistic than ever that the disease will soon be numbered among those conquered. We cannot regard the admittedly unusual (for an elderly person) course of the disease as being anything but coincidental to the B_{12} administration at this time because the preparation fed to the patient has a variety of factors known to be distinguishable from B_{12}. But that the increasingly apparent tonic and supportive properties of factors associated with B_{12} may play an important role in the ultimate management of the malignant leukoblastoses, is freely admitted.

SUMMARY

A patient with acute leukemia exhibited a sustained clinical remission while receiving a daily dietary supplement containing from 240 to 320 micrograms of B_{12}. The remission may have been purely coincidental but the results imply the complete innocuity of massive oral doses of B_{12}.

Addendum: July 1, 1950. The patient, taking 100 mgms. of terramycin daily is entering the eighth month of remission. The coliform suppressing antibiotic present in the fermentation concentrate was presumably responsible for the initial result because the senior author has now recorded 18 remissions in 29 acute leukemic patients given materials from antibiotic-producing streptomyces species.

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The Story Behind the Word

Some Interesting Origins of Medical Terms

Platinum—Platinum ore was discovered in Peru, South America in the middle of the Eighteenth Century by the Spaniards. They named it platina which is the diminutive of plata, the Spanish word for silver, because of its resemblance in color and appearance to that substance.

Radium—Professor and Madame Curie, the discoverers of this element, named it radium because of its intense radio-active powers.

Condom—The facts concerning the origin of this device are shrouded in obscurity. Turner in 1717 attributed its invention to a Dr. Conton, an Englishman who made a protective sheath from the sheep's cecum for covering the penis. Others ascribe the invention to a Frenchman, Monseiur de Condom. Still other authorities question the existence of either a Dr. Conton or a Monsieur de Condom and think that the name is derived from the Latin "condere" or "condus" meaning to hide or to protect.

Cough—An imitative word which is supposedly a description or imitation of the sound produced.

Lumbago—A hybrid term of both Latin and Greek origin. It comes from the Latin word "lumbus," the loin or haunch, with the "ago" portion of the word coming from a corruption of the Greek term "algos" or pain.

Pylorus—Gabriele Zerbi in 1502 described the muscles of the stomach and introduced the term pilorium, which was later purified by Vesalius to pylorus. This term was given to the lower orifice of the stomach because of its function. It is derived from the Greek word "pulore" meaning a janitor or gatekeeper and in turn comes from the Greek word "pule" or gate.

Corn—This common and troublesome condition of the skin of the toe or foot is so-called because it is a horny induration or excrescence. It is derived from the Latin word "cornu" or horn.

Chancre—This word is known to have been in existence since the beginning of the Fifteenth Century and is assumed to be a diminutive of the word "caries" which had long been applied to destructive genital lesions. The Latin word "caries" literally means decay or rottenness. Other authorities state that the term chancre is derived from the Latin "cancrum" meaning a cancer.

Sycosis—The name for this skin disease is said to have first been used by Heraclides in 75 B. C. The term sycosis is derived from the Greek word "sukon" a fig. Celsus in his De Medicina about 30 A. D. states: "There is also an ulceration called sycosis by the Greeks from its resemblance to a fig."

—Harry Wain, M. D., Mansfield, Ohio.

Chorionepithelioma of the Fallopian Tube: Report of a Case with Autopsy

OTIS G. AUSTIN, M. D.

THE most recent case of chorionepithelioma of the Fallopian tube to be found in the literature was reported by Smith and Werthesen in 1941.[1] Marchand described the condition first in 1895.[2] Because of the rarity of this disease, the following case is reported.

The Author

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REPORT OF CASE

Mrs. M. S. No. C-1967. This 32-year-old white woman, a patient of Dr. E. T. McCune of Sebring, Ohio, had four pregnancies prior to the present illness. Three pregnancies terminated in spontaneous abortion at six to twelve weeks before a normal child was born three years prior to admission. Her general health had been excellent. The menstrual history prior to the present illness was not remarkable. There were no previous operations.

The last normal menstrual period began November 1, 1947. On December 13, 1947, a laparotomy was performed by Dr. J. R. Caldwell at Alliance City Hospital, Alliance, Ohio, for a ruptured tubal pregnancy. The left tube was removed uneventfully. However, the pathologist, Dr. A. P. Falkenstein, noted unusual activity of trophoblastic cells and warned the surgeon that there was a possibility of malignant change. A Friedman test done January 10, 1948, was negative. On February 19 the patient was seen again, this time complaining of weight loss and nervousness. Examination was not contributory and the Friedman test was again negative. There was uterine bleeding for several days beginning the first week in January and again early in February.

On March 9, 1948, three months after salpingectomy, the patient complained of increasingly severe fatigue, nervousness, weakness and lower abdominal discomfort. A pelvic tumor was now noted on the left, separate from the uterus which was thought to be slightly enlarged. There was a small, flat, brownish area about 3 mm. in diameter on the posterior cervical lip at 7 o'clock. It bled easily. No abnormal cells were found in smears from the cervix and vagina. A Friedman test was strongly positive. X-ray examination of the chest revealed an opaque area 2 cm. in diameter in the right lower lobe. Laboratory studies of blood and urine were normal.

A diagnosis of chorionepithelioma was made, and on March 22, 1948, the abdomen was reexplored. A vascular and friable inoperable pelvic tumor was found to fill most of the left side of the pelvis extending nearly to the umbilicus. Hemostatic gel was placed over the surface of the tumor mass after the bleeding was controlled as well as possible and the abdomen was closed with drainage. The patient received 2500 cc. of whole blood within the next five days, plus antibiotics, parenteral fluids and Wangensteen drainage. On the third postoperative day the patient was moved to Mercy Hospital, Canton, Ohio. Teropterin® (sodium pteroyltriglutomate*) was given in doses of 10 mgm. daily intramuscularly for a week, then twice daily. The appetite improved and the patient felt better.

Deep X-ray therapy to both the chest and the abdomen was instituted. A total of 750 roentgen units was given to each of the four quadrants of the abdomen and to each side of the chest. X-ray therapy was not completed.

At two or three-day intervals she received six separate transfusions of 250-300 cc. whole blood. Donors were women one to four days postpartum. These transfusions were given in an effort to supply a "restraining factor" to the trophoblastic cells and to halt their invasive activity. Following each of the last three transfusions there was a mild chill followed by temperature rise to 102° - 104° F., so this approach was temporarily abandoned. The abdominal wound healed well.

On the seventeenth postoperative day there was a small amount of bloody sputum and pain in both sides of the chest anteriorly. Two days later there was evidence of massive internal hemorrhage with dyspnea, cyanosis, rapid, low volume thready pulse and nearly unobtainable blood pressure. Red blood count and hemoglobin dropped from normal to 1,700,000 and 33 per cent (5 Gms.), respectively. Administration of oxygen and supportive therapy revived the patient to a great extent but were necessary continuously thereafter. Moderate vaginal bleeding began on April 16, the twenty-fifth postoperative day. The patient expired April 19, 1948, twenty-eight days after the exploratory operation and four months after the original operation for tubal pregnancy.

AUTOPSY PROTOCOL

The body was that of a markedly emaciated, young white woman.

Abdomen: The abdomen was not distended. The peritoneal cavity contained about one liter of clotted and fluid blood. A mass filled the left side of the pelvis extending to 2 cm. below the umbilicus. It measured 10 x 8 x 10 cms., was spongy, red and necrotic and was adherent to the left cornu of the uterus. The sigmoid was

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* Lederle product which has been used experimentally to inhibit sarcomatous growth, and has not, to our knowledge, been used previously in treatment of this type of growth.

attached to the upper aspect of the mass over a distance of 20 cms.

Left tube and ovary, not visible. Right tube, normal in size. The ovary was polycystic, lobulated and measured 5 x 4 x 3 cms. Thick-walled cysts contained heavy dark semisolid material. No vaginal lesions.

The uterus approximately normal size, measured 4 cm. between the cornua, 8.5 cm. from fundus to cervix; 3 cm. thick at corpus. Uterus with attached adnexa and tumor mass weighed 550 gms. A small flat brownish area, 3 cm. in diameter, was seen at 7 o'clock on the posterior cervical lip. Endometrium was thin and pale, with no evidence of hemorrhage.

The liver was large and pale, weighed 2400 gms. and contained multiple lesions, from 2 to 6 cm. in diameter, which were circular, soft, red and necrotic. Cut surface showed numerous similar lesions throughout the liver tissue.

Nodes: Many small, firm lymph nodes were found in the mesentery and retroperitoneal area.

Thorax: In the right pleural cavity there was about 2 oz. of free blood. In the upper portion of the right lower lobe, and in the left upper lobe there were soft, rounded, fairly well demarcated masses, 2 to 4 cm. in diameter. Cut surfaces were hemorrhagic and necrotic.

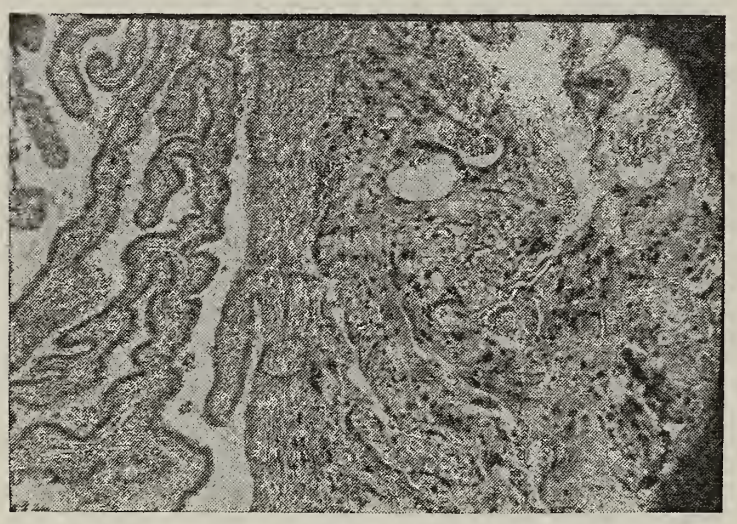


Figure I. Photomicrograph shows the uterine tube with invasion of the wall by both the syncytial and the Langhans elements.

Microscopic: Sections taken through the adnexal mass presented necrotic material with blood clots and vascular connective tissue containing considerable pigment. The right ovarian cyst contained blood. The cyst lining was made up of several layers of luteinized cells. Multiple sections through the cervix did not reveal tumor cells. The hepatic and pulmonary lesions contained blood and a great number of Langhans' or cytotrophoblastic cells. Also there were masses of cells having the characteristics of syncytium or plasmoditrophoblast. No villi were seen. Chorionic cells were present in the large pulmonary vessels.

DISCUSSION

Williams in 1938[3] reviewed the literature and reported a case in which a chorionepithelioma arose from a tubal pregnancy. He classified extrauterine chorionepithelioma according to origin, as follows:

1. Those in which the tumor follows ectopic pregnancy. This is apparently the most common type.
2. Those which follow intrauterine pregnancy, villi being transported during or subsequent to the pregnancy to the tube or broad ligament and without initial malignant lesion in the uterus.
3. Those which are purely metastatic from a primary growth in the uterus to extragenital locations.
4. Those which arise from chorionic cells in a teratoma, more common in the ovary.

A chorionic tumor of ectopic origin may be mistaken during operation for ruptured ectopic pregnancy and the true nature of condition remain unsuspected until metastases appear or autopsy is performed. Repeated hormonologic tests should be used in all suspected cases to follow the development of this condition.

Statistics pertaining to incidence and cures of chorionepithelioma must be accepted with reservation because of the unusual difficulties encountered in diagnosis. Chorionic cells are innately invasive, may enter blood vessels and lodge in lungs or other viscera even in uneventful pregnancies. The nature of the stimulus which initiates the malignant change is completely unknown. Likewise, there is no known cause for the dissolution of these wandering cells during the normal puerperium.

In cases of chorionepithelioma of extrauterine origin which were reviewed, the mortality rate was 93 per cent. Fatal cases usually proceeded rapidly to their termination. Williams' patient lived 22 months and Smith and Werthesen's patient lived nine months after the diagnosis was established. Our patient died four months following the operation for ectopic pregnancy.

Treatment of the disease should consist of radical surgery and supportive measures using blood transfusion liberally. Irradiation should be tried when feasible.

SUMMARY

A patient with chorionepithelioma of the Fallopian tube arising in a tubal pregnancy is reported. This is the forty-fourth case to be reported in the literature.

The difficulties of diagnosis are discussed. In this patient tests for gonadotropic hormone were not positive until anatomical evidences of recurrence were present.

Unusual details of treatment involved transfusions of whole blood from post-partum women donors and Teropterin,® terminally, which seemed to contribute to the patient's sense of well-being until her death.

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Intra-Abdominal Hemorrhage During Pregnancy from the Spontaneous Rupture of a Uterine Vein

FRANKLIN C. HUGENBERGER, M. D., JAMES M. McCORD, M. D., and CHARLES H. HENDRICKS, M. D.

RUPTURE of uterine veins constitutes one of the rare but dramatic complications associated with pregnancy. Harding and Concannon,[1] in 1943, found twelve cases in the literature and added one of their own. Lee[2] added another case in 1947. A survey of the literature since that time reveals no further cases and with the patient here reported the total stands at fifteen.

CASE REPORT

Mrs. D. R., a 34-year-old housewife, was brought to the Ohio State University Hospital on the evening of August 28, 1948, complaining of severe lower abdominal pain. She was para 0, gravida 4, having had three previous instrumental abortions. She was due to deliver on October 17 and was therefore slightly over seven months pregnant. There was a vague history of albuminuria in 1933, but otherwise the systemic review was negative.

The present pregnancy had progressed normally until the afternoon of admittance when the patient, while sitting quietly sewing, suddenly experienced severe low midline abdominal pain of such intensity that she was unable to walk. Two hours later the pain spread to the right upper quadrant of the abdomen and then into the epigastrium. She was taken to the hospital five hours later.

Examination revealed a well-developed, moderately obese white female who was acutely ill and in severe pain. The pain was such that she could move in bed only with great difficulty, and jarring the bed caused increased pain. There was, however, no shoulder pain. The blood pressure was 132/90, pulse 76, temperature 99.2 F. The fundus rose in the abdomen slightly higher than would be expected of a seven months' pregnancy and was markedly deviated to the right. There was generalized abdominal tenderness and voluntary spasm but no true rigidity. The fetal heart sounds were located in the left lower quadrant of the abdomen and were regular and of good quality. Sterile vaginal examination showed no bleeding. The cervix admitted one finger; the membranes were intact. There was mild pitting edema of the feet and ankles.

Laboratory examinations showed a red blood cell count of 4.55 M., and a white blood cell count of 28,950. A catheterized urine showed a trace of albumen, and the sediment was loaded with white blood cells. A flat plate of the abdomen showed a fetus in cephalic presentation, markedly deviated to the right. No other unusual findings were noticed.

Because of the presence of the numerous white blood cells in the urine the patient was examined in the Urology Department where a cystitis and a mild right hydronephrosis were noted, but these findings were not believed to be the major source of the patient's difficulty. About six hours after the first blood level, a second blood level was done. On this occasion the red blood cell level was 2.5 m. Her general condition had remained unchanged, and she had received three liters of 5 per cent glucose intravenously. The fetal heart was also unchanged.

The patient was taken to surgery with a preoperative diagnosis of hemorrhage into the peritoneal cavity of unknown origin. Rupture of the uterus and premature separation of a normally implanted placenta were considered. The possibility of ruptured uterine vein was mentioned, but not given serious consideration because of the extreme rarity of the condition. The possibility of pregnancy in the right horn of a bicornuate uterus was mentioned because of the position of the fetus in the right side of the abdomen. Under spinal anesthesia a low midline incision was made into the abdomen. Free blood amounting to approximately 1000 cc. was found in the abdomen but the source could not immediately be ascertained. A Caesarean section was deemed advisable and a live baby was extracted from the uterus through a transverse incision into the lower uterine segment. The placenta was extracted and the contracted uterus then examined. The anterior surface of the fundus was covered with blood clot and when this was removed blood was found to be flowing from a ruptured vein on the anterior surface of the uterus to the right of the midline. This was directly over the placental site. The bleeding was controlled with several catgut sutures. However, on reëxamining this area it was seen that oozing had reappeared and it was

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necessary to take several more catgut sutures in this area for hemostasis. It was found then that the pregnancy had occurred in the right horn of a bicornuate uterus. One thousand cc. of blood were given during the operation. The mother made an uneventful recovery. The infant, which weighed 3 lbs., 10 oz., at birth, was doing well one month later.

DISCUSSION

In seven of the fifteen reported cases the diagnosis was made at autopsy. Of the remaining eight cases one is reported above in detail; a brief survey of the other seven follows.

In 1928, J. K. Miller[3] performed a classical Caesarean section on a woman 31 weeks pregnant who had abdominal pain. The preoperative diagnosis was concealed accidental hemorrhage. He found 600 to 900 cc. of free blood in the peritoneal cavity but was not able to identify the source of bleeding until the uterine incision was closed. It was then seen that the bleeding was coming from a ruptured uterine vein and was controlled with a single catgut suture. The baby died a few hours after birth; the mother made an uneventful recovery.

In 1929, Modiano[4] operated a patient at 7½ months gestation with a preoperative diagnosis of ruptured uterus or peritonitis secondary to appendicitis. The abdomen was filled with blood and the source was recognized as a vein situated on the anterior surface of the uterus. Because of the possibility that another vein might rupture if the pregnancy continued, a Caesarean section was done. The infant died on the fourth day, the mother made an uneventful recovery.

In 1931, M. C. Falk[5] operated on a woman 26 weeks pregnant with a preoperative diagnosis of intra-abdominal hemorrhage, etiology unknown. A large amount of blood was found in the abdominal cavity. An area was found on the posterior surface of the uterus which bled when the surrounding blood clots were removed. A supra-vaginal hysterectomy was done. The specimen was examined and a six months fetus removed which died almost instantly. The bleeding area was shown to be a thin-walled vein. The mother made a good recovery.

In 1936, Neuman[6] did a Caesarean section on a woman at term but not in labor who had developed signs of intra-abdominal hemorrhage. A live child was delivered, but because the ruptured uterine vein was below the level of the internal os bleeding could not be controlled and it was necessary to do a supra-vaginal hysterectomy.

In 1939, G. Bulowsen[7] operated a patient in her 36th week of pregnancy with the diagnosis of premature separation of a normally implanted placenta. A large quantity of blood was found in the peritoneal cavity. A stillborn fetus was removed by Caesarean section. After the uterus was sutured it was seen that the bleeding was coming from a tear in a uterine vein located in the right horn of the uterus. The patient made an uneventful recovery.

In 1943, Harding[1] reported a woman 25 weeks pregnant with signs of intra-abdominal hemorrhage. She was operated with the diagnosis of accidental concealed hemorrhage. At surgery the abdomen was filled with blood. Careful search showed a small abraded area on the posterior surface of the uterus which oozed blood. A hysterectomy was done and a dead fetus removed. The uterus was resutured and the patient made an uneventful recovery.

In 1947, Lee[2] reported the case of a 31-year-old woman who was five months pregnant with signs of intra-abdominal hemorrhage. A laparotomy was done and 2200 cc. of blood found in the abdomen. The bleeding vein was at the base of the posterior right broad ligament. This was ligated and the abdomen then closed. The patient, who was in shock at the time of the operation, recovered but aborted a non-viable fetus on the day after surgery.

In only one of the above-reported cases was a viable infant obtained and in that case it was necessary to remove the uterus. In the case reported here a happy result was obtained in that a viable baby was procured and no procedure added to the Caesarean section except simple ligation of the bleeding vein.

Although a preoperative diagnosis of ruptured uterine vein would be difficult to make, it could be suspected in the presence of intra-abdominal hemorrhage with no external bleeding and a baby in good condition. With the diagnosis of intra-abdominal bleeding, operation is indicated and the source of the bleeding is then found. Caesarean section is probably advisable if the fetus is viable, because of the potential danger of recurrence of the hemorrhage. This procedure is to be followed by ligation of the bleeding vein.

Although this condition is rare its importance is attested by the fact that half the reported cases were autopsy findings.

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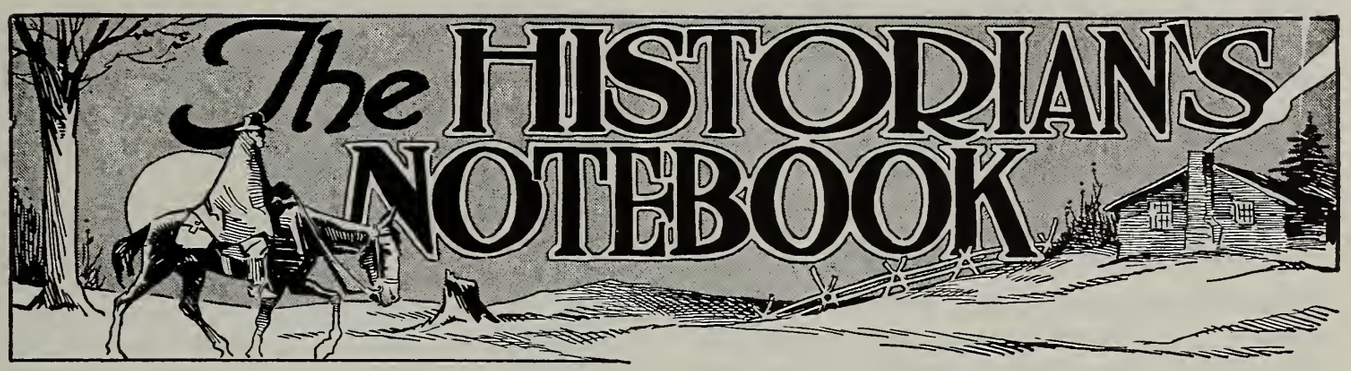
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Ohio Physicians in the Nineteenth Century, a Statistical Study

PART I

FREDERICK C. WAITE, Ph. D.

THE earliest physicians in Ohio came with the military expeditions or with the surveying parties late in the eighteenth century. Few, if any, of them remained to become resident physicians.

Three physicians came with the first settlers at Marietta in 1788 and three were in that settlement in 1800. The first resident physician settled in Cincinnati early in 1789 and two more came later in the same year. Others came but did not stay and in 1800 the settlement had three resident physicians. The first resident physician came to Chillicothe in 1796 and two were there in 1800. The first resident physician in the Western Reserve arrived in June 1800, the last year of the century.

These fragmentary records do not help to determine how many physicians were resident in the area that became Ohio when the census of 1800 estimated the population at 45,365. The early settlers were much given to self-medication and to treating their illnesses by domestic medicine. Nearly every community included a woman who acted as midwife and dosed with native herbs. The number of resident physicians when Ohio became a state in 1803 is conjectural, probably only a few hundred.

Search for contemporary estimates of the number of resident physicians in the state at any time prior to 1850 has been futile, and prevents giving statistics for the first half of the nineteenth century.

EARLIEST FIGURES FROM U. S. CENSUS

The United States census began in 1850 to list the number of persons in each of several occupations and professions, including medicine. The following table is from figures carried in the census from 1850 to 1900 inclusive. The number of the population for each resident physician is derived by dividing the population in each census year by the number of physicians and has long been called a ratio.

Table I

Year	Population	Number of Physicians	Ratio
1850	1,980,329	4,274	468
1860	2,339,511	4,238	552
1870	2,665,260	4,638	575
1880	3,198,062	6,393	500
1890	3,672,329	7,034	522
1900	4,157,545	8,448	492

In 1850, New York, with 5,060 physicians, was the only state that had more than Ohio and only eighteen per cent more although the population of New York was fifty-six per cent greater than that of Ohio. The ratio in New York was 612 compared to 468 in Ohio. This divergence and also the fact that the census figures for Ohio show fewer physicians in 1860 than in 1850 casts suspicion on the census figures of 1850 for Ohio and invites comment.

Instructions to census enumerators regarding occupations were to list them "according to the statements of the persons at their residences." Anyone could declare himself to be a physician. Ohio was afflicted with a large number of botanics, usually called Thomsonians, increasing rapidly after 1830. Each had paid $20 for a book containing a "right" to practice botanic medicine. It is probable that the

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census figures of 1850 and 1860 include many of these as well as of other cultists such as clairvoyants, euroscopists, "Indian doctors," magnetic healers, and mesmerists. As late as 1880 city directories in Ohio listed clairvoyants as a subdivision under the heading of physicians.

FIRST NATIONAL MEDICAL DIRECTORY

The first national medical directory was compiled by Dr. S. W. Butler and published in 1874. It was based on the number of physicians who had paid the Federal registration fee of $10 in 1873. It listed 4,583 physicians in Ohio. A second edition published in 1877 increased the number to 4,655. The first edition of Polk's national medical directory was published in 1886, the compilation having been in progress during two years. It carries the names of 4,947 physicians in Ohio. The second edition published in 1890 shows an increase to 6,469 in Ohio. The fifth edition was published in 1898 and shows more care in compilation. It was the issue nearest to 1900 and lists 8,231 physicians in Ohio. A medical directory of Ohio privately published in 1900 carries 6,444 names of physicians and is apparently incomplete.

DIRECTORIES AND CENSUS DATA COMPARED

Comparisons of figures of the directories with those of the census show the census figures constantly in excess, in some census years to the extent of several hundred. The source of these differences may be explained by two probabilities. The compilers of directories relied mainly upon medical societies for their figures and are likely to have missed many practitioners. The census enumerators probably continued to list as physicians those who were not so considered by the medical profession. Possibly census enumerators counted as physicians those druggists who prescribed over the counter and sold patent medicines. The local druggist was addressed as "doctor" in some communities, although he had no education in medicine beyond pharmacy.

FIRST A. M. A. DIRECTORY

The first edition of the directory of the American Medical Association was compiled in 1907 and lists 7,710 physicians in Ohio. Comparison with the number listed in Butler's directory of 1877 shows an increase of nearly sixty-six per cent while in these same thirty years the increase of population of Ohio was fifty per cent. The increase in census figures of physicians for the entire United States for thirty years from 1870 to 1900 was sixty-seven per cent.

CONCENTRATION OF PHYSICIANS IN CITIES

In seeking a clue to the approximate date when such concentration began the names in the classified lists of some city directories have been counted for five census years. The four larger cities of Cincinnati, Cleveland, Columbus, and Toledo were selected and the count was begun for 1860 because Toledo did not publish a city directory until 1858.

These counts have been combined for the four cities and the populations in these cities in these years have been combined. Subtraction of the two combined figures from similar census figures for the state as a whole has permitted derivation of three ratios for the five census years.

Table II

Years	Entire state	State outside 4 cities	4 cities
1860	552	546	615
1870	575	560	684
1880	500	483	615
1890	522	524	514
1900	492	510	440

These figures indicate that although the cities had fewer physicians in proportion to population in 1860, 1870, and 1880, a concentration of physicians in the cities began sometime between 1880 and 1890. The figures used for the ratios of the first and second columns are the suspicious census figures. The more reliable figures of city directories are used for the third column.

WOMEN PHYSICIANS IN OHIO

The United States census of 1850 did not include women physicians. They were included in 1860 but not separated. Male and female physicians were differentiated beginning in 1870. In 1870 the number was 42, nine-tenths of one per cent of the total; in 1880 the number was 341, over five per cent; in 1890 the number decreased to 287, four per cent; and in 1900 the number was 451, five per cent. The women were mostly sectarians because regular medical colleges rarely accepted women as students in the nineteenth century while the sectarian schools urged women to study medicine and used them to exploit their medical sects.

EDUCATION OF PHYSICIANS IN 19th CENTURY

Physicians of the nineteenth century fall into three groups as regards their education: those who received a medical degree in course; those who attended a medical college but were not graduated, either because of not attending two sessions required for the medical degree or from failure to pass examinations; and those who were never enrolled in a medical college, having received their entire medical education by study under a preceptor. A considerable number of the second group and a few of the third group later received honorary degrees of Doctor of Medicine. Conjectures were published at various times regarding the distribution of

current practicing physicians to these three groups but lack of reliable data prevented valid estimates.

Attendance at medical colleges was not popular in the eighteenth century either with practitioners or with students. The traditional procedure of study under a preceptor was dominant. The first medical degree in course in the American colonies was conferred in 1768 and from that year to 1800 inclusive only 276 men received degrees in course from ten different medical colleges, an average of little more than eight per year.

In the twenty years from 1801 to 1820 inclusive 1,905 men received medical degrees in course in the United States. More than 100 degrees in course were granted in each year after 1812, and in 1819, the year that the Medical College of Ohio was organized, 261 degrees in course were conferred. To this total number of medical degrees in course up to 1820 should be added a considerable number of degrees from European institutions and also some honorary degrees. From this combined total must be deducted those holding a medical degree who died before 1820, leaving approximately 2,000 holders of degrees in practice in 1820 when the population exceeded 9,650,000, an average of one holder of a degree to something less than 5,000 population.

Statistics of the number of recipients of degrees in medicine in each year throughout the nineteenth century are not available. With the founding of more medical colleges the proportion of physicians holding degrees steadily increased and also an increase occurred in the number that attended a medical college but did not receive a degree. The proportion of practitioners who had received all their medical education under a preceptor decreased correspondingly so that by the close of the century few men of this type were in practice.

A compilation from the lists of non-graduates of a few medical colleges shows that of all students who were enrolled in these institutions in the quarter-century session of 1824-1825 approximately one-half received a degree from that medical college or from some other institution after migration. The corresponding proportion for the mid-century session of 1849-1850 was two-thirds and for the session of 1889-1890, forty years later, the proportion was seven-eighths. These statistics representing only six different medical colleges show a trend in the increasing value placed upon the degree of Doctor of Medicine.

THE PROPORTION OF GRADUATE AND NON-GRADUATE PHYSICIANS IN OHIO

Few medical practitioners in Ohio prior to 1825 held the degree of Doctor of Medicine. Only nineteen degrees had been conferred in Ohio up to and including 1825. Few young men from Ohio went to eastern medical colleges because of distance and expense. The first medical student in an eastern medical college giving his residence as Ohio entered Yale Medical Institution in 1815. The physicians who came to Ohio in the early years were rarely holders of degrees. Men who received the degree of Doctor of Medicine in eastern medical colleges seldom migrated to new settlements in the West but remained in the East. Those coming in the first quarter of the century were almost entirely men who had received their entire education under a preceptor or perhaps had attended one session in an eastern medical college without remaining for a second session to get a degree. Biographical sketches of early physicians in Ohio support this general statement. The first directory of Cleveland was published in 1837. The classified list of physicans contained twenty-four names of whom only six held the degree of Doctor of Medicine, although holders of the degree tended to locate in larger communities.

COLLEGE ENROLLMENT GAINS WHEN CANALS SIMPLIFY TRAVEL

The opening of the Erie Canal in 1825 and of the Ohio Canal in 1832 simplified transportation and the number of students in medical colleges of New York and New England giving their residence as Ohio steadily increased. They were largely from northern Ohio. The number of Ohio medical students attending Transylvania University also increased.

A compilation of all medical students in twenty-seven eastern medical colleges for the sessions of 1812-1813 to 1838-1839 inclusive, arranged by the state which each student gave as his residence shows for residents of Ohio from 1812 to 1820 three students, from 1821 to 1830 forty-eight students, and from 1831 to 1839 one hundred and eighteen students in twelve different medical colleges. The number of individuals was fewer because those who received a medical degree attended two sessions and are therefore counted twice in these statistics. The largest total number at any one medical school during these twenty-seven years was at the College of Physicians and Surgeons of the Western District of New York at Fairfield, a total of forty-two. The next largest number was forty-one at Jefferson Medical College. These reliable figures show slight tendency for Ohio young men to go east for medical education prior to 1840.

(To be concluded in September issue)

The Epileptic Child in School

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THE epileptic child enjoys an increasing freedom in school and summer camps. Recent information about treatment is presumably responsible for release from restrictions on his physical and mental activities. Formerly thought to be hazardous to himself and his friends, the epileptic person is now encouraged to take part in athletics and continue with whatever academic training he may wish to do.

The Ohio State Medical Society and The Ohio Society for Crippled Children, Inc., worked out a plan with the object of attempting to improve circumstances under which the epileptic person lives in Ohio. Included among other professional and lay agencies whose assistance was sought are the Public Health Units, Division of Special Education, Services for Crippled Children, industrial nurses, school nurses, hospital authorities, Nursing School authorities and their pupils, Bureau of Vocational Rehabilitation and Ohio State Bureau Juvenile Research. Initial inquiries and follow-up of cases were carried out by the agencies interested in the health and welfare of the epileptic person.

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OHIO PLAN SUMMARIZED

The program is expedited through the "Ohio Plan" devised by The Ohio Society for Crippled Children, Inc. The plan in summary is as follows:

1. The Ohio Society for Crippled Children, Inc., selected epilepsy as one of its major functions.

2. The president of the Board of Directors appointed a small Steering Committee. This committee was composed of members of the board and its duties were administrative.

3. The Board of Directors created the Professional Advisory Committee on Epilepsy which is composed of three members from the Board of Directors; three representatives of the Division of Special Education, State Department of Education; two representatives of Services for Crippled Children, State Department of Public Welfare; two representatives of the Bureau of Vocational Rehabilitation, State Department of Education; one representative each from the Division of Mental Hygiene, the Bureau of Juvenile Research, the Division of Nursing of the State Department of Public Health, Departments of Neurology and Psychiatry, and Pediatrics, Ohio State University School of Medicine; and representatives of camping and recreation. Functions of the committee are principally advisory ones.

4. The Board of Directors also appointed a consultant to the Project on Epilepsy after seeking the advice of the Ohio Medical Society.

5. A secretary of the Project on Epilepsy was decided upon, a professional person, psychiatric social worker, being employed.

6. An educational-demonstration-consultation clinic was inaugurated after a series of conferences between the executive director, the consultant, and secretary of the Project for Epilepsy. In consultation with The Ohio Medical Society an outline was devised to conform to accepted medical ethics and the objective of the Project. The plan of the clinic is as follows:

a. A history blank is forwarded to the family physician after he has requested that one of his patients be seen at the clinic.

b. The physician is requested to return the history blank to The Ohio Society for Crippled Children before an appointment is made.

c. The physician is urged to attend the clinic with his patient, or requested to have some responsible person present.

d. A previously made diagnosis of epilepsy is confirmed, or the patient is referred back to the family physician with requests for further information, or suggestions for diagnostic tests are made.

e. Social, economic, and family problems are isolated as carefully as time will allow.

f. Suggestions for medical therapy and socio-economic readjustments are made in a letter to the family physician.

g. The problems presented by each case are discussed by the consultant with representatives of other agencies after departure of the patient.

7. Information concerning epilepsy is distributed by The Ohio Society for Crippled Children from the central office, 5 West Broad Street, Columbus, Ohio, and its four area field secretaries at kindred group meetings, the State

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Fair, etc., and the educational-demonstration clinics.

MATERIALS AND METHODS

An unselected group of 50 children in school ages were chosen for study, and a spontaneous report from each recorded. Few questions were asked for fear of eliciting incorrect information, the usual questions being: 1. Is your child in school? 2. Does he attend classes regularly or does he miss a measurable amount of schooling? 3. Have the school authorities talked to you about him? 4. Has he mentioned the other children to you? Similar non-specific questions were used in case information was meager, or to clarify school situations previously related to the examiner, in order to obtain uniform criteria for estimation of the school problem.

The objective of the study is to determine if the child is attending school and if so, how well he is doing. If not in school: Can he return to regular classroom activities? Does an attack interrupt classroom routine, and to what extent? Does the epileptic child disturb his classmates and the school authorities?

CASE REPORT

One patient is over 20 years of age. She related vividly her experiences of school, marriage and motherhood. Although she continued to have occasional seizures none occurred at a time when she was measurably inconvenienced by it. She stated that she is annoyed rather than depressed by the recurrent attacks. This case is included to emphasize the clinical course of uncomplicated epilepsy.

NOT A REPRESENTATIVE GROUP

There is no reason to believe that this group is representative of the epileptic population. The milder cases that respond well to medication are seldom examined in educational-demonstration-consultation clinics. The age distribution is distorted. The etiological agents are those common to this age group but unlike those of the 750,000 epileptic persons in this country.[1, 2]

The case material is standardized by determining the age distribution, etiology, classification of epilepsies, types of attacks, frequency of seizures, mental capacity, and results of treatment.

The study is derived from information obtained during the initial interview with the patient and those who accompanied him to the clinic. To complete the study a survey of the school policies and actual contact with the patient in school is anticipated.

The classification of epilepsy into idiopathic and organic (asymptomatic and symptomatic) is inadequate, and a classification for the epilepsies that would give a more accurate description of the child is suggested.

All figures used in this report refer to cases. Percentages may be obtained by multiplying the number of cases by 2.

RESULTS

AGE

Chart 1 gives the present, age of onset, and duration of seizures. The distribution of cases in this age group is similar to those of other observers[3] for this age group.

Years	Present	Onset	Duration of Attacks
0 - 4	0	18	18
5 - 9	13	13	16
10 - 14	25	15	11
15 - 20+	11	2	3
Unknown	1	2	2
Total	50	50	50

Chart 1—Age of the Patient in 5 year periods.

CLASSIFICATION

Chart 2 is the classification of the cases in both the accepted and proposed forms.

The etiology of epilepsy is generally conceded to be unknown. A predisposition for one to develop recurrent attacks may be brought to our attention by injury to the brain, low sugar content of the blood and other metabolic disturbances which are poorly understood. Recurrent seizures are found and no apparent cause is demonstrable. However, the diagnosis of epilepsy is made in all cases. In the absence of a demonstrable cause the group is classified idiopathic, asymptomatic, cryptogenic and others. Organic, symptomatic and other terms are used to designate those in whom a cause for the recurrent attacks is demonstrable.

In effect and by practices commonly accepted by physicians the idiopathic group includes all cases in which no structural damage to the nervous system can be demonstrated. All symptoms of the epileptic have been attributed to disturbances in the convulsive mechanism without regard to other well-known syndromes or diseases of the nervous system that might also be present. Influence of environment, social and economic, has been neglected. Mental illness and personality disturbances have been neglected both as a causative and perpetuating agent of recurrent attacks.

Modern psychiatry is discussing vigorously the functional or organic origin of mental illness, neuroses and personality problems. And, too, if originally "functional" does a disturbance later become a permanent "organic" deviation from the so-called "normal"?

Functions of the central nervous system are dependent on the integration of its structural and physiological units. This scheme is similar to other biological units and the brain is no exception. We are obligated to study separately "epileptics" with and without other diseases

or syndromes of the central nervous system that may have an effect on the physiological mechanism related to seizures or interfere with proper care of the patient and prevent superimposition of "functional" or "organic" disturbances on recurrent attacks. [4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17]

In order to avoid confusion in terms, let's consider the accepted classification as The Epilepsies even though it includes etiological inferences. The proposed form may then be considered a classification of the etiological or perpetuating agents or a combination of them. This distinction affords a better chance of evaluating the significance of presumably causal or perpetuating agents on seizures. In addition, it draws attention to the person who has seizures and also other problems which may be far more important to him than the recurrent attacks. A more detailed study of these principles will be discussed elsewhere.

The Epilepsies		Etiological Factors	
Idiopathic	24	Idiopathic	12
*Organic	26	Structural Cerebral Changes	21
		Physiological Cerebral Changes	15
		Miscellaneous	0
		Unknown	2
			50

* Cerebral Palsy—12, Trauma—4, Feebleminded—2, Thrombosis—1, Post-encephalitis—2, Agenesis—1, Undetermined—4.

Chart 2—Classification of the Epilepsies in Contrast to Etiological Factors.

The chart demonstrates that 24 children have seizures for which there is no demonstrable cause. Yet, those who have attacks but also have problems that may influence the onset, frequency and perpetuation of attacks are reduced from the total of 24 to 12 cases. "Idiopathic" is a reasonable term in the classification of these cases, namely, there are no other diseases or syndromes that could have an effect on the number and types of seizures. In the group classified as structural cerebral changes are those usually stated to be organic in type. Cerebral palsy, trauma and infections are included.

In the group physiological cerebral changes are those cases in which structural changes are minimal or absent but who suffer from emotional, mental and intellectual disturbances. The primary or secondary effects of these disturbances are important in attempts to evaluate the etiology of attacks as well as cause of social and economic maladjustments. The group is composed largely of children who are mentally retarded for which there is no apparent cause, social misfits, and "problem children."

The miscellaneous group includes the epileptics who have diseases of other organ systems from which metabolites or disturbances of blood supply causes isolated or recurrent seizures. Examples are complete heart block, hypoglycemia and uremia.

TREATMENT

Only seven, or 14 per cent, of the group had had treatment considered to be adequate.[18] The effect of medication can be determined most effectively after available medicines are used in quantities that will cause overdosage symptoms. The amount may then be reduced slightly so that the patient is comfortable.

Twelve children had had no medicine. Thirty-one had had dilantin, phenobarbital, bromides and tridione in small doses at irregular intervals. Other medicines used by individual physicians are known to the profession but are not universally prescribed in the treatment of seizures.

Adequate	7	Control	7
Inadequate	31	75 per cent	8
None	12	50 per cent	8
		None	10
		Worse	0
		No Medicine	12
		Undetermined	5

Chart 3—Treatment with Medicines and the Results.

The results confirm the opinion that treatment is inadequate (Chart 3). Seizures were decreased 75 per cent or more in 30 per cent of the group. This is in contrast to a similar reduction in the number of seizures in approximately 60 per cent of cases treated with a more vigorous medical regime.[19]

The total number of cases that received adequate treatment is too small to demonstrate statistically whatever effect it might have on disturbances caused by the epileptic child in the schoolroom.

ABILITY TO PERFORM SCHOOL WORK

Chart 4 shows that the epileptic child is similar to the average school student.

Marks	Cases
A	10
C	18
Ungraded	12
Home Teaching	2
Out of School	8
Total	50

Chart 4—Estimated Ability to Perform School Work.

If one considers the incidence of organic disease of the central nervous system in this group one would have difficulty in recognizing the epileptic child because of his ability in school,

and that is what is found by the school authorities. The problems of academic instruction for the epileptic child are similar to those of the non-epileptic child as will be indicated later in this report.

TYPES AND FREQUENCY OF SEIZURES

Chart 5 indicates the types of seizures. The high incidence of grand mal attacks, alone or in combination with other types of seizures may be the result of the incidence of both structural and physiological cerebral changes in this group. Grand mal attacks were described in 96 per cent—petit mal alone was found in only 4 per cent of the group.

One a week or more	20	
One per month or less	13	
Unknown	17	
Total	50	
Grand Mal		26
Petit Mal		2
Grand Mal + Petit Mal		14
Grand Mal + Psychomotor		3
Grand Mal + Myoclonus		2
Grand Mal + Petit Mal + Jacksonian		1
Grand Mal + Menieres-like Syndrome		1
Grand Mal + Jacksonian		1
Total		50

Chart 5—Frequency and Types of Attacks.

Of the 33 cases in which the frequency of seizures was known, twenty, 60 per cent, had one or more seizures each week. It is surprising to find that only six, 12 per cent, of the total group are stated to be unable to attend school primarily because of attacks even though seizures recurred so frequently.

The unknown group is composed of those who were uncertain or unaware of the frequency of seizures. Other problems such as objectionable mannerisms or asocial behavior distracted everyone's attention from the attacks.

The frequency of seizures is only one, and perhaps the least important, of the criteria for school placement in some cases. The so-called "running fits" or periods of malbehavior often related to seizures, though fewer in number than other types of attacks, may be more important than frequency of seizures in determining school placement for a child. Mental confusion following attacks caused a limited disturbance in this group—yet an important one. A rigorous treatment regime is necessary before the significance of seizures can be readily evaluated.

INTELLECTUAL DEVELOPMENT

Intellectual development was estimated and found to be distributed as shown in Chart 6.

	Cases
Normal	31
Abnormal	17
Undetermined	2

Chart 6—Estimate of Intellectual Ability.

Psychometric studies or estimation of the I. Q. by psychologists had been performed in a small number of the group. The estimates in Chart 6 were made from the child's ability to answer routine questions, solve arithmetic problems, his knowledge of current events and similar material. Estimation of the effect of emotional disturbances, inattention, behavior mannerisms, etc., on mental capacity was attempted, and proper allowances made for them. One is aware of the errors attendant to such a method. However, the results of psychological and clinical estimates of mental capacity were strikingly similar.

DISTURBANCES IN SCHOOL

In many discussions about education of the epileptic child the effect of seizures on the child's classmates or interruption of classroom routine prohibits, or promotes over-cautious placement of the patient in the private or public school system. Chart 7 shows that only six, or

Cause	Cases
None	16
Seizures	6
Other symptoms	28

Chart 7—Causes of Disturbances in School.

12 per cent, have seizures upon which the continuity of education depends. Sixteen, or 32 per cent, cause no disturbance in school even though nine of the children had seizures on the grounds or in the classroom of the school. Twenty-eight, or 56 per cent, disturb their classmates, or interrupt classroom routine because of malbehavior, mental impairment, or other symptoms resulting from an injury to or maldevelopment of the brain, infections and other causes.

Among the 16 children, or 32 per cent of the group who cause no measurable disturbance in school, the school authorities and their fellow students did not know about seven, 14 per cent, of them. They had had no attacks on the school grounds or in the classroom. The remaining nine children, or 18 per cent, had suffered one or more seizures while on school property.

Three children had attacks on the school grounds but none in the classroom. Six children had attacks only in the classroom.

In three cases the disturbance caused by a seizure was slight but the school authorities brought it to the attention of the child's family. The teacher and pupils were concerned about the first attack but worked out a scheme suitable to all so that the routine of the school was uninterrupted by subsequent attacks. Restriction from athletics was imposed on one boy because his seizures usually occurred after exercise. He was permitted to take part in other activities of the school and student body. One was unrecognized as an "epileptic child" because she had had only petit mal attacks in the classroom. Another child was well adjusted to being teased about her attacks — teased similarly as if she had freckles on her face or a wart on her finger and it disturbed her as little.

Seizures were described as the cause of the disturbance in school in six instances. One-half of this group were also mentally retarded but the attacks, or post-seizure symptoms, caused the school authorites to be concerned about the safety of the child or morale of the other students. One child had minor attacks that were followed by drowsiness. He was allowed to put his head on the desk and sleep for 20-30 minutes, the average duration of drowsiness. His classmates also wanted to sleep when they were drowsy—probably some of them wanted to shun their classwork duties and others merely wanted attention. The patient was persuaded to struggle through the period of drowsiness after attacks. Discipline in the classroom was easily restored.

One child occasionally had 20 seizures in one day. The teacher was frightened, and justifiably so. Another school was found. The teacher had had experience with "epilepsy." She was able to care for the child if he had an attack, and was instrumental in directing the child and his parents to a physician for medical care.

Another child, unknown to have "epilepsy" had a convulsion for the first time during a class. The teacher and all the students left the room. The principal of the school was called to the scene. After the acute symptoms had subsided he drove the patient home in his car. The patient returned to school the next day and has continued to attend classes regularly and without undue comment from either the teacher or his classmates.

Very frequent seizures in addition to mental retardation were described as the cause for the disturbance in school in the other 3 children. Two of them have been removed from school. The teacher has encouraged the other one to continue in school as regularly as possible, and classmates volunteer to care for him during an attack.

CARE OF PATIENT IN CLASSROOM

Gentle care of the patient and creation of a calm atmosphere in the classroom during the attack has been most helpful in preventing anxiety, tension, and fear of the seizure. One method of accomplishing this feat, and it has been used elsewhere, is worthy of note. A child fell from her seat in a grand mal attack during class. The sister in charge of the room instructed the children to continue with their work. The child remained by her desk where she had fallen until she recovered from the acute phase of the seizure. She was permitted to continue with her work if she was able to do so, or to go home if she felt ill.

Even though seizures recurred frequently in the remaining 28 cases, 56 per cent, disturbances in school were attributed to causes other than the attacks. The most prominent causes of interruption of school routine in this group are malbehavior and mental retardation.

Thirteen children, or 26 per cent, failed to meet the academic standards of the school or were so poorly behaved, or a combination of the two, that special care is required for them.

Specific recommendations were made for four children, all but one of whom were mentally and physically normal. Everyone is well-acquainted with the usual school policies of home instruction programs or blanket elimination of epileptics from school. They need not be discussed further except to call attention to the small number of children (2) on home teaching programs. One child's cousin had objected severely for years to the patient attending the same school. After the patient had completed the junior year in high school she had voluntarily withdrawn from school.

Intrafamily discord[20, 21] was described as the primary cause of school disturbance in six instances, or 12 per cent. In some cases, frequency of attacks, mental retardation and malbehavior are of much less importance to the school authorities than mother dependency, anxiety and fear of attacks. In one case a child's fear of an impending attack is more important to him than friends among his classmates and ability to perform good classwork.

Drug intoxication in three cases caused malbehavior and created an uncooperative aptitude for school. Overdosage or an idiosyncrasy to a medicine may cause malbehavior, irritability and other symptoms that are similar to well-known clinical syndromes, even though the child may be physically and mentally normal.

Social discord with her classmates was the only disturbance a senior in high school caused. Even though she had had no seizures in school, the president of the senior class knew of her

attacks and notified her that she would not be allowed to go on an educational trip to Washington, D. C., with the class unless her mother would accompany her. The patient learned that the president of the class had written to her without consulting her classmates. A special meeting of the senior class was called. The president of the class was forced to apologize to the patient for interpreting her personal opinions as senior class policies. The patient was then invited by her classmates to make the trip to Washington, D. C., without being accompanied by her mother.

One child is mute. A special school for the mute had rejected him because of questionable mental ability. An opinion was sought by those interested in him. Another child has a severe speech disturbance and infrequent attacks.

In summarizing the primary causes for disturbances in school, seizures are in the minority. Only in three instances are seizures described as such. In 16 instances the combination of mental retardation, malbehavior and seizures are causes for the disturbances in school.

In the remaining 15 out of 34 cases that caused disturbances in school, interruptions of the routine program are attributed to causes other than seizures. Realignment of attitudes about epilepsy with modern concepts of it by the school authorities, physicians and near relatives would most likely eliminate some of these disturbances in school. Improved care of the epileptic child would enhance the probability that only 17 children, or 34 per cent, would cause a disturbance in school, and that the disruption of routine would be attributed to mental or physical deviations from the normal rather than attacks.

HELPFUL CRITERIA BROUGHT OUT

Criteria that would be helpful in anticipating the disturbances an epileptic child might cause in school are brought out in this study. The older age group of children that seek treatment for seizures are least likely to interrupt classroom routine (Chart 8). The children whose seizures first occurred at the adolescent period caused the fewest disturbances of all. The period over which attacks recur is directly proportional to the likelihood a child will cause disturbances in the classroom.

Chart 9 partially explains the age group distribution of cause and effect of age on classroom disturbances. One may say that children who have no demonstrable cause for the attacks and whose near relatives require them to lead an active, constructive life will be of no undue concern to the school authorities or their classmates. The children in whom multiple causes or perpetuating agents for seizures can be demonstrated are usually slow mentally or behaviorly maladjusted.

Years	None	Seizures	Others
Present Age			
0 - 4	0	0	0
5 - 9	1	2	9
10 - 14	11	2	13
15 - 20 and over	4	2	6
Age of Onset			
0 - 4	2	4	12
5 - 9	3	2	9
10 - 14	10	0	4
15 - 20 and over	1	0	1
Unknown	0	0	2
Duration of Attacks			
0 - 4	10	1	7
5 - 9	4	1	11
10 - 14	2	2	7
15 - 20 and over	0	2	1
Unknown	0	0	2

Chart 8—Ages of the Patient, Onset and Duration of Attacks and their Influence on Disturbances in School in 50 Cases.

Classification	None	Seizures	Others
The Epilepsies			
Idiopathic	14	1	9
Organic	2	5	19
Etiological Factors			
Idiopathic	10	1	1
Structural Cerebral Changes	2	5	14
Physiological Cerebral Changes	4	0	11
Miscellaneous	0	0	0
Unknown	0	0	2

Chart 9—Classification in Accepted and Proposed Forms and their Influence on Disturbances in School.

RESULTS OF TREATMENT

The results of treatment and its influence on disturbances in school are a bit confusing on first glance (Chart 10). Only in the completely controlled group is there evidence of the necessity of medicines in the care of the epileptic child. The proportion of 1:2 children in the groups in which there is no disturbance in school, or if so it is caused by symptoms other than seizures, is materially altered only in those whose attacks are controlled. The proportion is reversed. The effect of inadequate dosage and irregular administration of medicines on disturbancs in school caused by the epileptic child awaits a more vigorous and critical trial of the anticonvulsant medicines. It is noteworthy, however, that children may and do

	None	Seizures	Others
C	4	0	3
75 per cent	2	1	5
50 per cent	2	2	4
None	3	2	5
No Medication	4	0	8
Undetermined	1	1	3

Chart 10—Medication and Its Influence on Disturbances in School.

attend school much as one would expect of them even though seizures recur at frequent intervals.

INFLUENCE OF FREQUENT SEIZURES

Frequent seizures (Chart 11) add to the probability of disturbances in the classroom. Seizures

	None	Seizures	Others
1/week	5	3	12
1/month	6	0	7
Undetermined	5	3	9

Chart 11—Frequency of Seizures and their Influence on Disturbances in School.

that recur at a rate of one per week or more are commonly accompanied or caused by other diseases of the nervous system, and symptoms of which are often as likely as attacks to be causative of schoolroom disturbances.

HOW MENTAL CAPACITY AFFECTS ROUTINE

Normal mental capacity is essential to the least number of disturbances in school an epileptic child is known to cause (Chart 12).

	None	Seizures	Others
Normal	16	3	12
Abnormal	0	3	14
Undetermined	0	0	2

Chart 12—Mental Capacity and its Effect on the Incidence of Disturbances in School.

Mentally normal children may become odd from either outside influences or whatever they might think of themselves and become classroom problems. However, this is true whether a child does or does not have attacks. A normal mental capacity minimizes the likelihood that outside influences might affect the child, or if so, he is capable of a good readjustment with guidance.

ENCOURAGING ADEQUATE ADJUSTMENTS MADE

Children that are and have been able to make a good adjustment to school in spite of their seizures are unlikely to upset the routine program of the classroom (Chart 13). Epileptic children are capable of adjustment to the social life of the school as well as to meet its academic requirements when suitably endowed and should be required to do so. A child, happily occupied, is least likely to cause disturbances in school. The children who are able to adjust to home or

	Regular	In Ungraded	Out	Home Teaching
None	15	1	0	0
Seizures	3	1	2	0
Others	10	10	6	2

Chart 13—Disturbances in School and School Placement.

playmate surroundings are unlikely to interrupt classroom routine. Intrafamily discord[19] plays a decided role in the adaptability of children and it is prominent in the epileptic child (Chart 14).

	None	Plus	Unknown
None	11	5	0
Seizures	3	3	0
Others	9	17	2

Chart 14—Disturbances in School and Their Relationship to Intrafamily Discord.

However, it is encouraging to see the number of children who have the opportunity both at home and school that make adequate adjustments and cause the school authorities and their fellow students no undue alarm about them.

The criteria that would decrease the incidence of disturbances in a routine school program is summarized in Chart 15.

SCHOOL PLACEMENT

Chart 16 demonstrates that 40 children, 80 per cent, are in school. It also shows that eight children, 16 per cent, are exempt from school, and two children, 4 per cent, have classes at home supervised by a visiting teacher.

School attendance is surprisingly high. Credit is due the physician, near relatives and school authorities for their painstaking placement of complex problems in a routine school program. Only one of the group attended a private school designed for the care of the epileptic child.[22]

The term "in school" means that the child is enrolled in school, is assigned to a desk, and is required to attend school regularly. The term "out of school" means that the child has discontinued all connections with the usual school

	None	Seizures	Others
Present age	10 - 20 years	5 - 14 years	5 - 14 years
Onset of seizures	10 - 20 years	0 - 9 years	0 - 9 years
Duration of seizures	0 - 4 years	10 - 20 years	0 - 9 years
Classification	Idiopathic	Organic	Organic
Etiology	Idiopathic	(2)	(2) and (3)
Response to medication	Controlled	Undetermined	Undetermined
Frequency of seizures	1/month	1/week	1/week
Mental capacity	Normal	?	Abnormal
School placement	Regular classes	—	Ungraded Classes Out of school

Chart 15—Summary of Criteria to Reduce the Incidence of Disturbances in School.

program within the community in which he lives. Home teaching programs of Departments of Education which permit children to receive instruction by a regularly certified teacher and be credited with school attendance are available in most states.

It is interesting to note in Chart 16 that of the 80 per cent that attended school, 28, or 70 per

In School	40
Regular Classes	28
Ungraded	12
Out of School	8
Home Teaching	2

Chart 16—Placement of the Epileptic Child by School Authorities.

cent, are included in regular classroom schedules. Sixteen of these 28 children, 46 per cent, have caused no undue alarm to their classmates nor have they been disturbed measurably by having had recurrent attacks. The remainder are in ungraded classes.

Unfortunately some epileptic children are not allowed to continue in school with one class from year to year. This is an unnecessary hardship in many instances. Yet the family of the patient, attending physician, the child and school authorities have arranged to continue with schooling according to chronological age or academic progress. At times, it is necessary to find a teacher acquainted with the care of the handicapped child and willing to work with him. This is true in both those in regular and in ungraded classes. In rare instances the family found it necessary to move to a new community and have been willing to do it.

INTRAFAMILY DISCORD RETARDS PROGRESS

In five cases intrafamily discord has interfered with an expected progress of the child. Over-protective families of the children have allowed them unusual liberties from studies and other responsibilities, which tends to cause anxiety, paternal dependency, and irresponsibility. For example, the parents of one child persuaded the teacher to allow him to develop poor habits in both studies and behavior. Another child was more cooperative and happier at school than at home principally because he was permitted to take part in school activities much as anyone else.

OTHER OBSERVATIONS

Toxicity of excessive doses of medicine caused three children to have lower marks, study less efficiently and become irritable and fussy.

Fear of the attacks by the teacher or teacher and students caused some concern to three children. Though not severe enough to prompt removal of the child from school, and usually with the first attack only, an adjustment to the seizure by classmates was necessary before routine classwork could continue without interruption.

Classroom discipline was interrupted by one child whose seizures were followed by drowsiness but which was corrected easily. Ignorance of the relationship of "petit mal" and "epilepsy" prevented trouble in one case. The patient had grand and petit mal attacks but had had only petit mal seizures in school. The attempt of the president of a senior class to impose her personal opinion about epilepsy upon a classmate has been previously described.

Mental retardation in one case is no obstruction to attending regular classes. He will be unable to progress academically with his classmates. He is capable of making a passing mark in the present school placement. Socially he is more easily adaptable to other children than if he had missed the experiences of association with his classmates.

Twelve of the 28 children in school are in ungraded classes. All but one of them are mentally retarded. Concern about them is a result of their poor behavior. Seizures recur at both frequent and infrequent intervals yet the children remain in ungraded classes because of inability to compete academically and socially with other children.

Mental retardation complicated by intrafamily discord is doubly troublesome to school authorities. In five cases intrafamily discord conceivably prevented the child from getting valuable social experience from his contacts with other children. Mother dependency, irritability and malbehavior in a mentally retarded child is very difficult to cope with and may even decrease a child's ability to accept instruction or profit by experience.

Physical defects that interfere with expression or reception of knowledge may retard academic progress in an otherwise normal child. Two of this group are in ungraded classes, and justifiably so, yet they may be mentally normal. One has a marked speech defect, and the other is mute. Correction of or compensation for these physical handicaps is indicated before it is possible to determine if they should be in regular classes.

A sense of social adjustment is independent of intellectual ability. Four children are carried along in school consistent with their chronological rather than mental ages. Academic work is minimized or omitted. Social experiences are encouraged with gratifying results.

Only one mentally normal child is in an ungraded class. He has had no attacks in school. Seizures recur about every two months. He has had no medication.

SCHOOL EXEMPTIONS

Similar to the group in school, those out of school are almost as perfectly selected. One

would expect that it would be easier for the school authorities to exempt rather than find a place in their program for an epileptic child. That is not the case in the public schools of Ohio.

Only eight out of 50 children were exempt from school. Two children have teachers who hold classes for them in their homes.

Six of the eight cases exempt from all school programs are mentally retarded. Their behavior is incorrigible. Most of them suffer frequent seizures.

Two cases deserve special attention. One is a girl who voluntarily withdrew from school because her cousin objected to her presence in the school building. A second child had attended school for six years. Each year he had been promoted to a higher grade. The physician in charge of the case urged both the family of the patient and the school authorities to continue his education. The school authorities objected to having him in school. The family was afraid he would hurt himself during an attack as he had to walk between one and two miles for a school bus. On one occasion he had fallen in a snow bank, his clothes became wet and he had been exposed to severely cold weather. A visiting teacher is unavailable to carry out a home teaching program.

OHIO'S HOME TEACHING PROGRAM

The home teaching program in Ohio is reported to be an excellent one. Only two children have "home teachers." Scarcity of visiting teachers partly explains this low figure. The majority of those formerly carried on home teaching programs are in school even though academic work is kept at a minimum. There are a number of teachers and children who accept the more unfortunate child and are undisturbed by their peculiar habits and mannerisms. Indeed, some children assume a parental attitude and care for the mentally retarded, behavior problem child more efficiently than adults. Surely the social education for both the usual and unusual child is well worth the program in school as revealed in this study. For those who are abusive and destructive, individual care is indicated.

ERRORS MINIMIZED THROUGH ANALYSIS

Errors in placement of epileptic children in school may be minimized by observing generally the criteria brought out by this study. Undoubtedly some mistakes will be made as experience is gained by those responsible for placement of the children in school.

SPECIAL CLASSES FOR SOME

Children, the first of whose recurrent attacks occur during adolescence, and who are seen in the clinic soon afterwards, are more likely to take part in a routine school program than those whose seizures are first noticed early in life and who have received treatment over a long period of time (Chart 17). The latter group are more commonly required to attend special classes, or if within the usual classroom schedule

Years	In Regular	In Ungraded	Out	Home Teaching
Present Age				
0 - 4	0	0	0	0
5 - 9	5	4	3	1
10 - 14	16	7	2	0
15 - 20+	7	1	3	1
Unknown	0	0	0	0
Age of Onset				
0 - 4	8	6	4	1
5 - 9	5	4	3	1
10 - 14	13	1	0	0
15 - 20+	1	1	0	0
Unknown	1	0	1	0
Duration of Attacks				
0 - 4	14	3	0	1
5 - 9	7	6	3	0
10 - 14	5	3	3	0
15 - 20+	1	0	1	1
Unknown	1	0	1	0

Chart 17—The Age Distribution and Placement in School of 50 Unselected Children.

allowances are made for them. The dual role of a school program, namely academic and social instruction, permits including the more unfortunate child in regular classes. Indeed, social adjustment is far too often independent of academic ability to be ignored by an institution of learning.

	In Regular	In Ungraded	Out	Home Teaching
The Epilepsies				
Idiopathic	21	0	2	1
Organic	7	12	6	1
Etiological Factors				
Idiopathic	12	0	0	0
Cerebral Injury	6	8	6	1
Psychiatric	9	3	2	1
Miscellaneous	0	0	0	0
Unknown	1	1	0	0

Chart 18—Classification, Accepted and Proposed Forms and School Placement.

Chart 18 indicates that inability of the examining physician to demonstrate structural changes in the brain enhances the probability that a child may attend classroom activities much as anyone else. Injury to or infections of the brain often prohibit academic progress,

and too, unstable, emotionally labile children are equally difficult to integrate in a well-organized classroom schedule.

	In Regular	In Ungraded	Out	Home Teaching
Control	5	0	1	1
75 per cent	5	2	0	1
50 per cent	6	1	1	0
None	3	4	3	0
Worse	0	0	0	0
No Medication	6	5	1	0
Undetermined	3	0	2	0

Chart 19—The Results of Treatment and Its Effect on School Children.

Control of seizures, 50 per cent or more, Chart 19, enhances the probability that a child will attend regularly the average classroom schedule. The children who receive no help from medication, if they have had any, or who are undecided as to the effect of medicines on the number of attacks are most likely to be found in ungraded classes or excused from all contacts with a school program. The results are about as one would expect them to be yet a more rigorous medical regime is required to obtain comparable figures.

	In Regular	In Ungraded	Out	Home Teaching
1/week	9	6	3	2
1/month	8	4	1	0
Undetermined	11	2	4	0

Chart 20—The Effect of Frequency of Seizures on School Placement.

Chart 20 demonstrates the effect of frequency of seizures on placement. A child who has attacks at intervals of once a month or less is likely to be included in regular classes. Seizures found to recur at intervals of one each week or more is a determent in school placement; yet, some of them attend regular classroom schedules. However, seizures recurring so frequently are very commonly associated with malbehavior and sub-par mental ability the combination of which, are indications for placement in an ungraded class; or the child might be excused from school.

PLACEMENT REQUIRES GREAT CARE

Chart 21 demonstrates the importance of mental capacity. Our school system is standardized on the basis of academic work performed by the students. It is not surprising that the normal is found in regular and abnormal in ungraded classes or excused from school attendance. However, it is surprising to find the degree of perfection with which children have

In	Normal	Abnormal	?	
Regular Classes	27	1	0	
Ungraded Classes	1	9	2	mute-speech
Out of School	2	6	0	
Home Teaching	1	1	0	

Chart 21—Mental Capacity and School Placement of 50 Unselected Children.

been placed in school and with minimal criteria. The general concensus of opinion by educators has been that epileptics should be placed with great care, if at all, except in an institution designed for them.

REALISTIC APPROACH BENEFICIAL

Chart 22 demonstrates that children who are able to accept epilepsy as a handicap without undue alarm and whose near relatives are least upset by seizures are more likely to be found in regular classes at school. Indeed the children

In	None	Present	Unknown
Regular Classes	18	10	0
Ungraded Classes	3	8	1
Out	2	5	1
Home Teaching	0	2	0

Chart 22—Intrafamily Discord and School Placement.

in ungraded classes are usually more severely affected than those in regular classes and the near relatives have cause for greater concern about them. However, regardless of the severity of seizures, or other symptoms, a realistic approach to the problem enhances the likelihood that the average epileptic child has a good chance of continuing with his classmates from year to year and even the more unfortunate children may attend school regularly.

Chart 13 demonstrates that only about one-half of the children in regular classes cause a disturbance of class routine. Behavior of children of this age group with perhaps greater deviations than expected is handled by school authorities who are acquainted with it even though seizures recur. However, the "problem child" or "conduct disorders" that cause disturbances in the classroom more often than seizures indicate placement in ungraded classes if not exclusion from school. A thorough trial in school is justifiable before a hopeless attitude keeps one

from properly locating the group that can be helped and probably kept out of institutions designed for custodial care.

A summary of the criteria is given in Chart 23.

	In		Out	Home Teaching
	Regular	Ungraded		
Present Age	10 - 19 yrs.	5 - 14 yrs.	5 - 14 yrs.	----------
Age of Onset	10 - 19 yrs.	0 - 9 yrs.	0 - 4 yrs.	5 - 14 yrs.
Duration of Attacks	0 - 5 yrs.	5 - 10 yrs.	5 - 10 yrs.	----------
The Epilepsies	Idiopathic	Organic	Organic	----------
Etiology	Idiopathic	Structural	Structural	Structural
		Cerebral Changes	Cerebral Changes	Cerebral Changes
	Physiological	Physiological	Physiological	Physiological
	Cerebral Changes	Cerebral Changes	Cerebral Changes	Cerebral Changes
Treatment	C - 75 per cent	None—50%	None—50%	C—75%
Frequency of Seizures	1/month or less	1/week or more	1/week or more	1/week or more
Mental Capacity	Normal	Abnormal	Abnormal	----------
Disturbance in School	None	Others	Others	Others

Chart 23—Summary of Criteria for Placement of Epileptic Children in School.

COMMENT

An increased efficiency of placement of the epileptic child in school under the supervision of tolerant, understanding authorities automatically minimizes disturbances in school caused by seizures and other problems. Selection of children for summer camp programs designed for the average child was successfully carried out by the National Association to Control Epilepsy, Inc. The Association worked closely with the E-P-I Center (formerly the Baird Foundation Clinic). Only children well adjusted to their illness and whose seizures were well controlled were able to continue successfully with an eight weeks summer camp period. The authorities, unlike the school authorities of Ohio, were reluctant to accept, or keep in summer camp, anyone except the mentally and physically normal child.

The criteria for selecting children for school or summer camp programs are similar and not unlike those of employment, motor vehicle licensure, insurance, and marriage. In some instances, as in the summer camp program mentioned above, complete freedom of attacks is essential. That is not always the case as demonstrated in this study. Recurrent attacks need not interfere with one's mental and physical ability to perform whatever duties are assigned to him. This study stresses the point that one need not be free of attacks to attend school if those in charge of the school are tolerant and understanding.

A thorough understanding of why epilepsy is a handicap is essential to the epileptic person who hopes to be successful and happy. Nonetheless important is the attitude of those with whom he comes in contact. Both parties must realize that seizures are, in the main, unrelated to mental capacity, personality and behavior with few exceptions. Epilepsy is an illness with limited characteristics that may interfere temporarily with one's ability to perform whatever responsibility may be undertaken. With some forebearance for concurrent illnesses, symptoms common to the conditions that are stated to cause epilepsy and the result of poor environment, the usual epileptic is strikingly similar to the usual child. The unusual epileptic is, in like manner, similar to the unusual child.

One must remember that the material presented here is obtained from the patient or a responsible person who accompanied him to the clinic in addition to information furnished by the attending physician. And too, the data presented may be the impressions the patient or responsible person received from the school authorities, or their self-expressed desires and wishes for school placement. An entirely different point of view might be obtained from the school authorities. If so, it is important to know what the differences may be. A clearer understanding and a realignment of opinions about epilepsy are essential to proper placement of the child in school.

Documentary evidence is presented for the successful selection of children for school placement. Only four children are malplaced in school. One is a mentally normal boy 16 years of age. He is in an ungraded class. He has had no medicine. Presumably he has only one grand mal seizure every two months. He is becoming disinterested in his school work and apathetic about making friends among his classmates. To what extent poor habits have added to his problems is difficult to estimate.

Two mentally and physically normal children are out of school. One because her cousin objected strenuously to her attending the same school. Another, a boy, was exempt from school over the attending physician's objections. Exemption from school was requested by the child's family because they feared he might be severely injured during an attack.

Another mentally normal girl was recommended for a home teaching program. Seizures

were soon brought under control but she continues to receive instruction in the home.

Review of the school program for the more severely handicapped child is required from time to time. Readjustments are made and correctly so as demonstrated in a surprisingly high percentage of this group.

SUMMARY AND CONCLUSIONS

1. School attendance of fifty unselected school children is reported. Information obtained from the patient, his family, persons responsible for him, and the attending physician is the basis of this study.

2. A proposed classification of Etiological Factors may increase the accuracy of school placement.

3. Statistical data are presented to show that epileptic children are in school even though they may have frequent seizures and treatment is inadequate.

4. The epileptic child's ability to perform routine school work is strikingly similar to other children.

5. This study also demonstrates that the severely handicapped child, mentally and physically, is in the public school system in Ohio.

6. Mental capacity is similar to that expected of this age group.

7. School placement is strikingly accurate. Eight out of ten are in school and of this group, seven out of ten are in regular classes. Fewer than one in ten are assigned to home teaching programs. The remainder are exempt from all school programs.

8. The study indicates that seizures are less bothersome than mental retardation, malbehavior and social maladjustments to the school authorities.

9. Four children who might be expected to attend classes regularly were found to have special care. Exemption from school because of seizures, is limited to six children.

10. Placement of children in school is found to be largely a result of cooperation of the relatives, teacher and family physician.

11. Clinical criteria are offered with the hope that, by using them, malplacement of epileptic children in school may be minimized.

Note: The author is grateful to the officials of the Ohio State Medical Association for their assistance in helping formulate the program of the educational-demonstration-consultation clinic and to its members who so graciously supported the clinic. The untiring efforts of the executive director of The Ohio Society for Crippled Children, Inc., are largely responsible for the success of the clinic. The ease and grace with which the program was integrated with responsible persons is due the secretary of the project, namely, Mrs. Lois T. Schneider. The recording secretary, Mrs. Virginia Seymour, was diligent and thorough in carrying out the objectives of the clinic. Mr. Paul Brown's wise guidance and encouragement at difficult moments is appreciated. Mrs. Mary Elliott assisted materially with excellent public relations, timely placed, and well organized. The personnel of the Office of Vocational Rehabilitation assisted materially. Cooperation of the Division of Special Education was unselfishly granted to us. It is impossible to mention many others who so energetically participated in the program and to whom the success of the program is largely due. However, I do hope they will now accept silent appreciation formerly expressed to them in person.

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Ohio Golf Tournament . . .

More than 90 Doctors Take Part As Dr. T. R. Shoupe of Findlay Wins Top Honors in Twenty-Fifth Annual Tourney at Sylvania Club, Toledo

By ROBERT W. ELWELL
Executive Secretary, Academy of Medicine, Toledo

THE Silver Anniversary Tournament and Annual Meeting of the Ohio State Medical Golfers' Association was held on June 14, 1950, at the Sylvania Country Club, Toledo. Dr. R. C. Young, Chairman of the Local Committee and his hard working committee members provided the excellent facilities of a difficult course and beautiful club house. Considering the lack of advance publicity due to commitment difficulties, the attendance of 93 golfers was gratifying. Twenty-six new fellows were initiated into membership at the meeting. The fine weather, a welcome change from many previous tournaments, made for many low scores.

ASSOCIATION CHAMPIONSHIP

Dr. T. R. Shoupe of Findlay toured the woody and sand-trapped Sylvania Course in the following scores (38-38-42) for 118 to become the 25th champion of O. S. M. G. A. Dr. H. T. Sargis, Lakewood, was right behind the winner with scores of 42-36-41 for 119 to place as runner-up. The following doctors were also awarded prizes for low gross in the 27-hole event. E. A. Sawan, Akron, 121; C. Donatelli, Toledo, 123; R. P. Bell, Sr., Cleveland, 124.

18 HOLE EVENT

The honors for low gross in the 18-hole play went to Dr. Julian Harrison, Napoleon, with an 83. Dr. N. G. Mathieson, Toledo, was runner-up with an 86. The following tabulation of scores is given with net scores shown (Handicaps figured by the Peoria System):

Flight "A" Handicap (0-13)

27 Holes

J. P. Bolton, Columbus	106
D. W. English, Lima	108
W. F. Lovebury, Columbus	112
H. B. Kaufman, Zanesville	112
A. D. Piatt, Newark	112
S. D. Zuker, Toledo	112

18 Holes

R. K. Ameter, Bryan	75
A. V. Boysen, Lakewood	76
F. T. Gallagher, Cleveland	76

Flight "B" Handicap (14-18)

27 Holes

D. J. Alsbaugh, Columbus	106
A. W. Franklin, Akron	106
J. S. Olms, Toledo	114
R. H. Hoecker, Mt. Vernon	116
R. M. Johnson, Lima	116

18 Holes

I. Colvin, Edon	72
John Cameron, Defiance	76

Flight "C" Handicap (19-30)

27 Holes

W. B. Devine, Zanesville	106
C. E. Cassaday, Mt. Vernon	108
T. L. Edwards, Van Wert	109
R. L. Adair, Lorain	109

18 Holes

J. Davidson, Springfield	72
A. A. Brindley, Toledo	74
J. Lampus, Lakewood	74

Dr. Jerome Ziegler, of Cincinnati, won the past-president's prize, presented by President Wilcoxon. Dr. H. R. Mayberry, Bryan, was the winner of the Special Event, closest to the pin on tee shot, with a close measurement of 3 feet 8 inches.

INTER-COUNTY TITLE

The Ohio State Medical Association presented four individual desk trophies to the winner of the Inter-County event. The Cleveland foresome had low score of 339 to nose out Toledo by two strokes. The Cleveland team had the following gross scores—Bell, Sr., 83; Bell, Jr., 84; Vinci, 84; and Rambousek, 88.

NEW OFFICERS ELECTED

The Annual Meeting was called to order by the president, Dr. George Wilcoxon of Alliance. The secretary read the minutes of the previous meeting and gave the treasurer's report showing a balance of $182.78 on hand following the 1949 tournament.

The following officers were elected and installed into office: Dr. F. M. Green, Columbus, president; Dr. Joseph Rinehart, Springfield, president-elect; Dr. E. B. Young, Lima, vice-president, Robert W. Elwell, Toledo, secretary-treasurer.

Several cities in the State issued invitations for the 1951 Annual Meeting. Zanesville was awarded the honor of entertaining the Association in 1951 by a majority vote of the fellows.

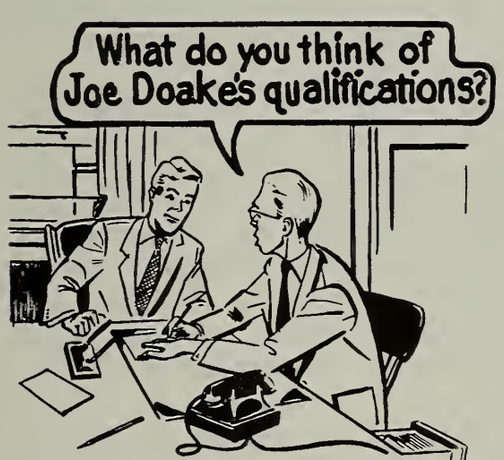
"Many enlightened scholars have expressed doubt as to whether any government can take more than two days in ten from the people, or 20 per cent of the nation's income and still leave a people able to take care of themselves. Above that level, Socialist management becomes inevitable."—*Hon. Ralph W. Gwinn, Congressman from New York.*

Doctors Must Be Citizens!

Doctor, to discharge your duties as a citizen—especially at this time when the election of sound, well-qualified persons to public offices is of vital importance to the medical profession—you must perform these three simple —but all-important—steps: Qualify yourself to vote in the November 7 General Election, learn all you can about the various candidates, and go to the polls on November 7.

1. Determine that you are qualified to vote. If you reside in a registration area, go to the office of your County Board of Elections and register if you have not already done so. If you are in such an area, in order to vote you must have voted within the prior two years or have registered in that time. Better check with your Board of Elections on these matters. Also see that members of your family, your friends, neighbors, etc., are qualified to vote. The deadline for registration is September 27—40 days before the election.





2. Acquaint yourself with the qualifications and views of the candidates for office—all of them—local candidates are important, too. Determine how each stands on matters of vital concern to the medical profession. Discuss the eligibility of each with your colleagues and others. The legislative committee of your county society can give you valuable pointers. Get out and work for good candidates.

3. Vote on November 7. See to it that members of your family, your friends, neighbors, etc., vote. That's the only way for you to have a voice in what goes on in Congress and in the Ohio Legislature; to have some influence over the actions of public executives. Medical and health issues are—will continue to be—potent issues on all fronts. The doctor who doesn't vote this year is a real slacker.



Licensed Through Endorsement by State Medical Board

The Ohio State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians, through endorsement of their licenses to practice in other states:

June 16, 1950—Karl S. Alfred, Cleveland, Long Island College; Albert W. Barile, Dayton, Loyola; John P. Bartle, Columbus, Univ. of Manitoba; Norman E. Berman, Cleveland, Georgetown Univ.; Donald F. Blair, Cincinnati, Columbia Univ.; N. Berneta Block, Sandusky, Univ. of Mich.; Ewing T. Boles, Jr., Columbus, Harvard Medical School; James W. Boyd, Columbus, Wayne University; Stephen J. A. Bruny, Toledo, Vanderbilt Univ.

Dayton R. Clark, Dayton, Univ. of Mich.; Oscar W. Clarke, Gallipolis, Medical College of Virginia; Theodore S. Cobbey, Jr., Canton, Harvard Medical School; Charles Jean Cooley, Oberlin, Univ. of Louisville; Harney M. Cordua, Jr., Cleveland, Northwestern Univ.; Robert H. Davis, Columbus, Univ. of Louisville; Edward L. Doermann, Toledo, Univ. of Cincinnati; Ralph E. Dwork, Columbus, Anderson Medical College; Harry Feilchenfeld, Columbus, Univ. of Berlin; Paul F. Fletcher, Cincinnati, Meharry Medical College; Walter R. Gillette, Jr., Columbus, New York Univ.; Leonard Gottesman, Cincinnati, St. Louis Univ.; David Guttmann, Dayton, Univ. of Berlin.

Gamble S. Hall, Dayton, New York Medical College; William Myron Hall, Cleveland, Howard University; Dean F. Hammond, McArthur, Louisiana State Univ.; Evelyn E. Hartman, Cincinnati, Univ. of Helsinki; Richard B. Heintz, Gallipolis, Indiana Univ.; Robert J. Hemphill, Barberton, Univ. of Louisville; Mark H. Huckeriede, Circleville, Indiana Univ.; Thomas R. Huxtable, Jr., Worthington, College of Medical Evangelists; Melford I. Johnson, Toledo, Jefferson Medical College.

Dorothy M. Kay, Cleveland, Univ. of Michigan; Kay W. Kennedy, Canton, Marquette Univ.; Emanuel J. Levin, Cincinnati, Univ. of Penna.; Howard Levitin, Columbus, Southwestern Univ.; Richard B. Magee, Cleveland, Univ. of Penna.; Richard R. Lininger, Cincinnati, Univ. of California; Harold W. Mammen, Toledo, Univ. of Louisville; Harry Nenni, Kalida, Medical College of Virginia; Harry W. O'Dell, Akron, Indiana Univ.; Norman L. Paul, Dayton, Univ. of Buffalo; Eugene F. Poutasse, Cleveland, Harvard Medical School; Robert Charles Prophater, Greenville, Medical College of South Carolina.

Aimee Richmond, Columbus, Woman's Medical College; John W. Rousseau, Columbus, Univ. of Michigan; Eugene W. Rumsey, Cleveland, Univ. of Southern California; Peter Saunders, Dayton, Univ. of Pecs; Eugene J. Schmitt, Xenia, St. Louis Univ.; Max Serog, Dayton, Univ. of Giessen; H. Stewart Siddall, New London, St. Louis Univ.; Earl C. Sifers, Cleveland, Univ. of Kansas; Lawrence A. Stevens, Columbus, McGill University; George G. Stitzinger, Wooster, University of Pittsburgh; James R. Strain, Cleveland, Louisiana State Univ.; Charles M. Suttles, Conneaut, Jefferson Medical College.

James T. Taguchi, Dayton, Univ. of Colorado; George J. Tenoever, Cincinnati, St. Louis Univ.; John G. Thomsen, Cleveland, Univ. of Iowa; Gordon M. Todd, Toledo, Washington Univ.; Bernard Virshup, Canton, Long Island College; Lewis H. Walker, Cleveland, Indiana Univ.; Robert G. Warnock, Youngstown, Univ. of Maryland; Richard W. Watts, Rocky River, Western Reserve Univ.; Siegfried Werthammer, Columbus, Univ. of Vienna; John A. Whieldon, Worthington, College of Medical Evangelists; Edward J. Zyla, Dayton, Wayne University.

Navy Civilian Intern Training Program Offers Full Pay to Applicants

The U. S. Navy has announced that it still has a number of openings for candidates for the Navy-sponsored Civilian Intern Program for the year 1950-1951.

This program is open to all graduates of approved medical schools who are qualified for commission as Lieutenant (jg), Medical Corps, U. S. Naval Reserve, and who have contracted for one-year rotating type internships in approved civilian hospitals.

Successful candidates are commissioned and placed on active duty at the time of commencing or during intern training. During the year of internship they receive the pay and allowances of their grade as well as other benefits that accrue to a reserve officer ordered to active duty—that is, transportation of dependents and shipment of household effects from their homes to place of internship, the regular uniform allowances, etc.

Applicants for the program are required to volunteer for and agree to serve a period of at least two years on active duty following completion of internship. During this latter period they receive the additional compensation of $100 per month accorded to medical and dental officers of the Regular service and of the Reserve when on extended active duty for a period of one year or longer.

Interested candidates should apply to the Officer-in-Charge of the nearest Office of Naval Officer Procurement. Such offices are located in Cincinnati, Ohio; Detroit, Mich., and Pittsburgh, Pa. These offices are in position to furnish full particulars of the program, to provide the necessary application forms, to conduct physical examinations and to assist in any other way.

Miners' Medical Care Plan . . .

After Temporary Suspension, U. M. W. Welfare and Retirement Fund Is Again in Operation; Revised Instructions for Doctors Are Issued

AFTER temporary suspension last September of payments by the Welfare and Retirement Fund of the United Mine Workers of America, it was announced recently that the hospitalization and medical care program is again in operation as of July 1, 1950.

In announcing resumption of the program, Dr. Leslie A. Falk, Pittsburgh, Pa., area medical administrator, forwarded a leaflet entitled "Information for Physicians" which contains the following data:

I. GENERAL INSTRUCTIONS

These instructions relate to the provision of medical care benefits for members of the United Mine Workers of America, their wives, and their dependent children who have not reached their eighteenth birthday. The Area Medical Office will furnish specific information not included in these instructions which are intended to provide general information only.

A. IDENTIFICATION

Members of the United Mine Workers of America and their dependents must show you Form 85-HS to obtain service at the Fund's expense. This form lists the names of the member, his wife and his dependent children under 18 years of age. **Please note that only those dependent children under 18 years of age may receive benefits. The birth dates of all children are listed on the form to enable you to determine whether a child has reached his eighteenth birthday.** This form must bear the seal of both the District and Local Union. It must be signed by the member and his wife before you accept it as evidence of eligibility for service.

A child born after the member gets his Form 85-HS is eligible to receive the hospital and medical care herein described, even though his name does not appear on the Form 85-HS.

A widow and her children are not eligible to receive service. The benefits herein described are available only during the lifetime of the member.

B. SERVICES

Services may be provided at Fund expense only by hospitals, physicians, and other individuals with whom the Fund has made specific arrangements for such service, or when services are authorized in advance by the Area Medical Office.

1. Hospitalization—The Fund will reimburse hospitals for ward or semi-private accommodations unless the condition of the patient is such that a private room is necessary. If the patient insists on private accommodations when not medically indicated, the patient must be responsible for any difference in cost. All necessary services may be provided except:

a. Obstetric service—unless such service is medically indicated and is authorized in advance by the Area Medical Office. The Area Office will advise you concerning the information which must be submitted to secure such authorization.

b. Tonsillectomies and Adenoidectomies—unless such service is authorized by the Area Medical Office. The Area Office will advise you concerning the information which must be submitted to secure such authorization.

c. Care of mental illness after diagnosis has been established.

d. Services which the patient can receive from other agencies, either voluntary or governmental.

e. Services which the employer or another third party is legally obligated to provide.

f. Personal services such as telephone calls, radio, etc.

2. Professional Services in the Hospital—The Fund will pay the cost of necessary medical care in the hospital when patients are hospitalized in accordance with the provisions listed above.

3. Out-Patient Hospital Care—Services may be provided in the out-patient department of a hospital in accordance with specific arrangements established between the Area Medical Office and the individual hospital.

4. Specialist Service—Patients requiring the service of a specialist may be provided such service when it is authorized in advance by the Area Medical Office. The Area Office will advise you concerning the information which must be submitted to secure such authorization.

5. Dental Care—The Fund will pay for dental services incident to the hospital care of a patient, and those which contribute toward any illness which may necessitate hospitalization. Such dental care must be authorized in advance. The Area Medical Office will advise you concerning the information which must be submitted to secure such authorization.

6. Eyeglasses—The Fund will pay for eyeglasses in those cases necessitated by surgical procedures involving the eyes.

7. Prosthetic Appliances—Physicians who prescribe orthopedic and similar appliances may request the Area Medical Office to furnish them

the names of suppliers with whom arrangements have been made for the purchase of such items.

8. **Emergencies**—In the event of an unquestionable emergency, the Fund will reimburse any hospital or physician at reasonable rates for services rendered its beneficiaries which are within the scope indicated above. Eligibility must be established as soon as possible. The Area Medical Office should be notified within 24 hours of admission of the patient and should be given factual information upon which the emergency character of the case is based.

II. SUBMISSION OF BILLS AND REPORTS

The physician will use the Fund's Invoice and Report Form 101-HS (Revised 7-1-50) or authorization Form 84-HS (Revised 7-1-50) for billing. The following are the instructions for the preparation of these forms:

1. The member's social security number, District and Local Union numbers, and the patient's name must be listed as shown on the member's Form 85-HS.

2. The spaces for birth date, and miner or dependent must be completed.

3. Discharge diagnosis and surgery performed must be entered.

4. "Patient was Hospitalized:" All appropriate blanks must be completed in this block. The date of admission, discharge or transfer is particularly important.

5. If this is a bill for professional services provided in the hospital, the name and address of the hospital must be entered in the appropriate space.

6. **The invoice must have the date of service or inclusive dates of services rendered.**

7. The type of service rendered must be clearly stated.

8. The patient's signature is not mandatory on bills submitted for a physician's services. It must be on invoices submitted for hospitalization.

9. The vendor's certificate must be signed.

10. The original (with stub attached) and duplicate are to be submitted to the Area Medical Office. The triplicate is for the physician.

11. Payment will be expedited if the invoice is submitted in sufficient detail to permit its prompt approval. Whenever it is necessary for the Area Medical Office to return an invoice for additional information, there is a material delay in payment.

PLEASE NOTE—IMPORTANT

Please submit bills promptly. It will be assumed that any material delay in submission of your bills is evidence that you are not concerned about prompt payment. Bills submitted promptly will be given priority in processing and payment.

Failure To Vaccinate Is Not Neglect Under Sec. 1639-3, Court Rules

"When the father of a minor child endeavors to send such child to a proper public school but, pursuant to a valid regulation of the board of education, such child is excluded from that public school because he has not been vaccinated, and where there is no showing that the father has done anything to prevent the vaccination of such child, such child is not a neglected child within the meaning of Section 1639-3, General Code."

The foregoing quotation is the syllabus of an opinion rendered in June by the Ohio Supreme Court.

In the case which originated in Hamilton County, school authorities refused to admit the 7-year old son of the defendant until the child had been immunized against smallpox in compliance with the customary school board regulation. The father attempted to return the child to school on at least two occasions, but each time school authorities refused to admit him. The Juvenile Court subsequently found the defendant guilty of contributing to the neglect of the child under Section 1639-3, G. C. The Court of Appeals of Hamilton County upheld the Juvenile Court, upon which the case was appealed to the Supreme Court.

The Court in its opinion called attention to a section of the General Code which reads: "Boards of health, councils of municipal corporations, and trustees of townships, on application of the board of education of the district, at public expense, without delay, shall provide the means of vaccination and immunization to such pupils as are not provided therewith by their parents or guardian."

The opinion further states that attention had been invited to no law requiring a father to provide for the vaccination of his son. "There was no evidence offered by the state tending to prove that the defendant prevented the vaccination of his son . . ."

In an opinion concurring with the majority opinion, the Court stated: "This concurrence is to make plain that we are not opposed to vaccination and do not criticize the board of education for preventing the attendance in school of any unvaccinated child. The way is pointed out in the majority opinion for the correction of this situation."

Dr. Christopher Daniels, of London, English physician, addressed a joint meeting of the Rotary and Kiwanis Clubs of Columbus on July 10 on the subject, "Socialism in England." His tour of the country is sponsored by the national education program of Harding College, Searcy, Arkansas.

Tuscarawas School Health Conference . . .

Medical Society Exchanges Ideas on Problems of Growing Program by Inviting Cross Section of Local Groups To Take Part in Discussions

THE Tuscarawas County Medical Society set an excellent example in the field of Medicine and School health relations when it staged a community-wide program entitled "Improving Our School Health Program."

Persons representing a cross section of the county's population were invited as well as out-of-county authorities on the subject of school health and medicine. Approximately 100 persons attended the meeting on June 8 in the New Philadelphia Elks Club. They included physicians, dentists, P.-T. A. personnel, county health personnel, educators and civic leaders.

That county people are vitally concerned in better health for their children, was voiced by Dr. Thomas Shaffer, of Columbus, who said that because of the cross section of people represented, the meeting was one of the most inspiring he had attended. Dr. Shaffer is chairman of the School Health Committee of the Ohio State Medical Association, is medical director of University School and a faculty member at the Ohio State University College of Medicine.

Dr. Shaffer pointed out that about 85 per cent of school children need dental care; about 20 per cent have something wrong with their eyes; one out of ten is hard of hearing; one out of ten has a speech problem; one out of five shows signs of becoming neurotic or psychoneurotic; about half have serious health problems.

Speaking in behalf of educators, Mr. H. C. McCord, superintendent of Worthington schools, spoke on the subject, "The Educator's Role in the School Age Child." He advocated among other things, better lighting in school rooms, walls painted in light shades, a follow-up pro-



Photo Courtesy The Daily Times, New Philadelphia

Taking part in the Tuscarawas County Medical Society's School Health Program were the above persons. Left to right, seated, are: Mr. Hart F. Page, Columbus, field secretary for the Association; Miss Edith Myers, Columbus, nursing consultant of the Ohio Department of Health; Mr. H. C. McCord, superintendent of Worthington Schools; standing: Harvey C. Janke, D. D. S., Cleveland; Dr. Thomas Shaffer, Columbus, chairman of the Association's Committee on School Health; Dr. Carl A. Lincke, Carrollton, Past-President of the Association; and Dr. Paul Q. Peterson, Columbus, assistant director of the Ohio Department of Public Health.



Photo Courtesy The Daily Times, New Philadelphia

Members of the Committee on Arrangements for the Conference are shown above. They are: Dr. S. H. Winston, Dr. Elizabeth Rowland-Aplin, and Dr. R. B. Hines.

gram on dental care and a good public relations program in the school community.

Dr. Harvey C. Janke, instructor in public health dentistry, Department of Preventive Medicine, Western Reserve University, spoke on the subject, "Dentistry's Participation in the Health of the Community." Dr. Janke pointed out that the blame for decay and pyorrhea is largely due to poor diet habits. He blamed the excessive amount of sugar in the average American diet for 97 per cent of dental diseases.

Dr. Paul Q. Peterson, assistant director of the Ohio Department of Health, Columbus, urged that an effective follow-up system for physical examinations be instituted in school health programs. An examination is useless, he said, unless there is a follow-up through the home. Dr. Peterson discussed the legal responsibilities of health departments, especially in the fields of sanitation and nutrition services.

An audience discussion followed presentations of talks and interest was shown by the number of questions that were directed to speakers.

Dr. Carl A. Lincke, Carrollton, immediate Past-President of the Ohio State Medical Association, presided at the meeting. Dr. Lincke was presented to the audience by Dr. William E. Hudson, president of the Society, who opened the meeting. In addition to Dr. Lincke and Dr. Shaffer, the Association was represented by Mr. Hart F. Page, Columbus, field secretary.

The committee on arrangements included Dr. Elizabeth Rowland-Aplin, chairman, Dr. S. H. Winston and Dr. R. B. Hines.

Dinner was provided for the group by the Woman's Auxiliary to the Tuscarawas County Medical Society.

Activities of The Editor

Following are some of the activities engaged in by Dr. Jonathan Forman, Editor of *The Journal* during the first half of 1950:

He addressed Phi Theta Pi in Columbus; as president of the organization, he presided at the American Conclave of Allergists in St. Louis; he held public hearings in Denver, Colorado, on transfer cuts as a member of the National Forest Advisory Council; spoke before the Lions Club of Chillicothe; attended the National Conference on Rural Health in Kansas City, as a representative of the Ohio State Medical Association; spoke before the Adult School at Farmersville.

He spoke before the Alumnae of the Grant Hospital School of Nursing; the Collegiate Assembly of Medical Evangelists in Los Angeles; the Hilltop Business Men's Association, Columbus; attended and spoke at the Friends of the Land Conservation Forum at Memphis, Tenn.; took part in the Ohio Valley Society of Allergists meeting in Dayton.

He addressed the Mothers' Club of Delaware; the Child Conservation League of Mt. Gilead; the Pittsburgh Garden Club; he presented prizes to the farmers of the Farm Bureau Soil Conservation Contest; addressed the Child Conservation League of Marion; took part in the Health Work Shop, Institute for Education by Radio; spoke before the Columbus Bar Association, the Underwriters' Association, the Committee on Medical History and Archives of the Ohio Archaeological Society and the 24th Annual Convention of Phi Rho Sigma medical fraternity at Macatawa Lake, Mich.

Reallocation of Federal Health Funds . . .

In Place of Former Procedure Whereby State Department Furnished Personnel, Share to Local Units Will Be in Form of Cash Deposits

A NEW method of allocating Federal grant-in-aid funds to local health departments has been put into effect in Ohio, Dr. John D. Porterfield, director of the Ohio Department of health, announced.

Federal monies granted for public health purposes may be used to support state activities or as assistance to local health department programs, Dr. Porterfield explained. Actually, approximately one-third of the Federal funds allocated to the Ohio Department of Health is used to supplement the state appropriation for support of central department activities, one-third is expended in direct services or professional assistance to local health departments, and one-third is reallotted to local health departments to supplement local support.

FORMER PROCEDURE CUMBERSOME

Until the recent change was made, the reallotment to local health departments has been in the form of employment under State Civil Service of public health personnel and their assignment to local units. This has been cumbersome in that all administrative procedures relative to employment, promotion, separation, and leave of such personnel have had to be carried on through the State Department, Dr. Porterfield continued.

The procedure has led to inequities in that state-paid personnel in the same local unit, and with the same assignment, have been on different pay scales. It has led to inefficiency in that state-paid employees have not always been understood to be under the functional direction of the local administrator.

EFFECTIVE JULY 1

The old procedure has been discontinued effective July 1. Under the new procedure, local health departments qualified for Federal assistance receive direct cash grants. Such cash grants are deposited with the local auditor to the credit of the local board of health and will be budgeted and expended by that body in the same manner as locally derived funds are disbursed.

This method has the advantage of providing more flexible assistance and ensures that local programs will be entirely under the direction of the local boards, the director explained. A copy of the budget of such funds must be forwarded to the Ohio Department of Health for Federal auditing purposes.

Payments of the grants will be made quarterly and will be in an amount adequate to bring unexpended Federal grant funds up to 25 per cent of the annual grant. By this system lapsed funds will revert to the Ohio Department of Health and annually to the Federal government.

MUST MEET REQUIREMENTS

Local health departments must meet certain requirements in order to qualify for Federal aid. A department to be qualified at the present time must meet the following requirements:

(1) It must be under the direction of a full-time health commissioner—one who confines his activities to the field of public health and preventive medicine. If not a medical person, as Ohio law permits in city health districts, there must be available qualified medical consultants.

(2) The health commissioner, one public health nurse, one sanitarian, and one clerk must be paid entirely from local funds (local funds are here interpreted to include the state-appropriated subsidy provided under Section 1261-39 of the Ohio General Code).

(3) The personnel of the health department must be employed under a merit system, either through civil service commission or by regulations established by the local board of health.

(4) The local health department must conform to the requirements of state law and the Ohio Sanitary Code and must submit the required reports to the Ohio Department of Health. The program content of the local department is at the discretion of its board of health with such consultation as it may request from the Ohio Department of Health.

SOURCES OF FUNDS

Local grants this year will be derived from Federal grants in the categories, approximately as follows: General health, 26 per cent; maternal and child health, 21 per cent; venereal disease control, 15 per cent; tuberculosis control, 20 per cent; cancer control, 12 per cent; and heart disease control, 5 per cent. It is anticipated and urged that local boards of health consider the original source and intent of the grants when developing the budgets for expenditures.

Some $616,000 will be allocated to 62 local health departments in the coming fiscal year, Dr. Porterfield announced. These 62 units are

qualified under the foregoing requirements and have requested such assistance.

Previously the amount of financial aid obtained by a local health department has been determined on an almost completely subjective basis, and has been conditioned by the urgency of the request of the local health commissioner and the frequently undocumented judgment of the State Department.

In order to establish a fair and equitable distribution on an objective basis, the amount to be allocated to each qualified department has been determined by a formula. This formula is based on the population of the local health district and the economic level as determined by the per capita tax duplicate.

Additional influencing factors are the rurality of the local district and the amount appropriated locally for public health. In no case will the Federal assistance be more than the local appropriation.

LOCAL RESPONSIBILITY

The 1950 local appropriation has been established as a base line and a reduced appropriation in any future year will result in an equal reduction in grant amount, Dr. Porterfield stressed, adding in explanation that these factors are established in accordance with the philosophy that support of local health units is primarily the responsibility of local government. They also prevent the conservation of local funds by substitution of Federal assistance.

It is the principle of the Ohio Department of Health, he continued, to provide all assistance possible to local health departments in their program activities with the least amount of control compatible with the accounting for expenditure of public funds.

These recent changes, the health director concluded, were recommended by the Annual Conference of Local Health Commissioners and are approved by the U. S. Public Health Service and the U. S. Children's Bureau, and are intended to strengthen that principle.

ASSISTANCE SINCE 1936

Ohio has received financial assistance in public health from the Federal government since 1936. These grants have been made in various categories from year to year. Programs specifically designated have included general health, maternal and child hygiene, venereal disease control, tuberculosis control, industrial hygiene, cancer control, hospital facilities administration, heart disease control and water pollution control. Other grant-in-aid funds are made toward mental hygiene and crippled children's programs, but these are administered by the Ohio Department of Public Welfare.

Some of these funds have been available only recently, Dr. Porterfield explained, and some of the appropriations have been discontinued.

Dr. Schriver Honored at Conference Of State Associations' Officers

Dr. L. Howard Schriver, of Cincinnati, was honored at the fifth annual Conference of Presidents and Other Officers of State Medical Associations in San Francisco on June 25, by being presented a gavel for having made "notable contributions to the progress" of the national organization.

With presentation of the gavel the following citation was read:

"As a member of the first executive committee of this Conference, and subsequently as its President in 1947-48, Dr. L. Howard Schriver of Cincinnati, Ohio, made notable contributions to the progress of our national organization.



L. H. SCHRIVER, M. D.

"Past-president of the Cincinnati Academy of Medicine, member of the Council of the Ohio State Medical Association for several years, and later President of that State Association, past-president of the Public Health Federation in his native city, and for several years now President of Associated Medical Care Plans, the national Blue Shield programs, and also president of Ohio medical Indemnity, Incorporated, Doctor Schriver has contributed immeasurably to the progress of medical organization in this country and to the development of voluntary health insurance.

"On this occasion the Conference of Presidents would remind Doctor Schriver of its appreciation of the contribution he made to the progress of this Conference as its President in 1947-48, by awarding him this gavel suitably engraved."

Michigan To Hold Annual Meeting In Detroit, Sept. 20-22

The 85th Annual Session of the Michigan State Medical Society will be held in Detroit, September 20-22. Complete information may be obtained by writing the Society at 2020 Olds Tower Bldg., Lansing, Mich.

Among eminent physicians who will take part in the scientific program are the following from Ohio: Dr. Charles A. Doan, Columbus, dean of the Ohio State University College of Medicine; Dr. Earl W. Netherton, Cleveland; Dr. Paul M. Moore, Jr., Cleveland; Dr. Charles F. McKhann, Cleveland; and Dr. William A. Altemeier, Cincinnati.

Ground will be broken this summer for a $13,600,000 addition to Henry Ford Hospital, Detroit. The new 17-story clinic was made possible by a gift from the Ford Foundation.

Medical Board Examinations . . .

Licenses as Doctors of Medicine Sought by 273 Appplicants; Osteopaths And Limited Practitioners Also Apply; Examination Questions Are Listed

LICENSES to practice medicine and surgery in Ohio were sought by 273 medical school graduates at the examination of the State medical Board held in Columbus, June 14-17.

Eighteen applicants took the examination to practice osteopathic medicine and surgery. Examinations in the limited practice fields were taken by 41 chiropodists, 31 mechanotherapists, 54 chiropractors, 24 masseurs and 9 cosmetic therapists.

Results of the examinations will be announced following a meeting of the Board scheduled for August 8.

Following are the written examination questions asked those applying for licenses to practice medicine and surgery:

ANATOMY

1. Discuss the anatomy of the afferent and efferent innervation of the heart.
2. Discuss the anatomy and relations of the external auditory canal and tympanic membranes.
3. Describe the anatomy which may be seen on anoscopic and proctoscopic examinations.
4. Describe the innervation of the Dura mater.
5. What are the respective relations of the vagina?

PHYSIOLOGY

1. Describe the anatomical structure and the physiological properties of cardiac muscle that peculiarly fit it for the function it performs.
2. Describe the part played by the various receptors that enable an animal (cat, dog, or man) to maintain an upright position and a normal postural orientation with respect to its environment.
3. What is the function, and state the importance of the plasma proteins of the blood? Discuss their formation by the body and their fate.
4. Explain the effects of a moderately severe hemorrhage on (a) lymph production; (b) heart rate, and (c) urinary output.
5. It is stated that food with a high fat content is "indigestible." Is there any physiological basis for this belief?
6. Account for the fact that the velocity of the pulse-wave along a large artery is not the same as the rate of flow of the blood within the vessel.
7. Discuss the factors which determine the activity of the gastric glands.
8. Discuss the nature of spinal shock.
9. In the human being at rest, the output of the left ventricle is about 5 liters per minute. During vigorous muscular exercise the output may attain 12-15 liters per minute. Account for this change.
10. Discuss the sources and energy for muscular contraction.

BACTERIOLOGY

1. List the distinctive characteristics of two pathogenic members of the Clostridium group.
2. Name four spirochetal diseases of man, exclusive of syphilis. List the procedures which must be carried out to establish the diagnosis in any one of these.
3. Outline the etiology and the laboratory diagnosis of Weil's disease.
4. Outline the life cycle of trichinella spiralis. How may the diagnosis of trichinosis be made?
5. List the important morphological and biochemical characteristics essential to identification of an organism as Vibrio Cholerae.

DIAGNOSIS

1. Give the signs and symptoms of deficient parathyroid secretion.
2. Give the blood chemistry in chronic glomerular nephritis and so-called essential hypertension.
3. How would you differentiate migraine from histemic headache?
4. What do you understand by polyendocrine disturbance? Name conditions in which this occurs.
5. In what bone conditions would you expect to find Bence Jones proteinuria?
6. Name three conditions in which free fluid occurs in the abdomen?
7. Give the signs by physical examination of air in the plural cavity—also fluid.
8. Differentiate sacro-disc sprain and a dislocated intervertebral disc.
9. Give findings (on physical examination) of chronic emphysema. broncho spasm and so-called asthmatic heart condition.
10. Differentiate Meniere's disease and spasm of cerebral arteries.

CHEMISTRY

1. To what extent is fat digested and absorbed from the alimentary tract of healthy individuals? Discuss the factors that influence this digestion and absorption.
2. By what qualitative tests may cholesterol be detected?
3. What is the approximate concentration of chlorides in the blood? Under what conditions may a hypochloremia be observed?
4. Define gluconeogenesis. Discuss briefly one procedure by which it is possible to determine whether a compound is gluconeogenetic.
5. Under what conditions may the nitrogen balance be positive? What is the significance of a positive nitrogen balance?

MATERIA MEDICA AND THERAPEUTICS

1. Define chemotherapy. State its object.
2. Compare the action of morphine and atropine.
3. Describe briefly the process of elimination of the following drugs from the body: (a) sodium phenobarbital; (b) opium; (c) procaine hydrochloride.
4. Name two conditions in which plasma is preferred to whole blood.
5. Give the action of heparin in prolonging the bleeding time.
6. Give the therapeutic effects of the methylanthines on the circulation.
7. Outline treatment of diabetic acidosis.
8. Classify the cathartics.
9. Give the treatment of lead poisoning.
10. Give indications for the use of digitalis.

PRACTICE

1. Give symptoms of pulmonary tuberculosis.
2. Give the etiology and symptoms of Brucellosis.
3. Give the complications of diabetes mellitus.
4. Give the etiology and complications of gout.
5. Give the etiology and symptoms of Erysipelas.

PATHOLOGY

1. What is meant by the term ulcer? Name four situations in which ulcers occur. Outline the gross pathological characteristics of an ulcer in one of these situations.
2. Describe in outline form the microscopic appearance of the wall of a syphilitic saccular aneurysm of the aorta. What portion of the aorta is most often affected?
3. Discuss in outline form the pathogenesis of bronchiectasis.
4. In a single sentence state what role, if any, the bone marrow plays in each of the following disorders? (a) lymphoid leukemia; (b) acute appendicitis; (c) carcinoma of breast; (d) Hand-Schuller-Christian Syndrome; (e) Phenol poisoning.
5. In outline form, distinguish between the gross appearance of a tuberculous and a typhoidal ulcer of the ileum.
6. Outline the microscopical appearance of the kidney in a fatal case of traumatic shock. Name two other conditions that may have similar effects on the kidney.
7. In reference to the microscopical appearance of an epithelial tumor of a glandular organ, outline briefly the features that would justify a diagnosis of carcinoma.
8. Name the diseases or conditions in which the following are observed: (a) Caseation necrosis; (b) Bence-Jones proteinuria; (c) secondary amyloidosis; (d) lower nephron nephrosis; (e) Langhan's giant cells.
9. How may a Health Department determine whether a sample of milk has been pasteurized?
10. What is the mode of transmission of the following

diseases; (a) psittacosis; (b) tularemia; (c) undulant fever; (d) anthrax; (e) Rickettsialpox.

OBSTETRICS AND GYNECOLOGY

1. Discuss the causes, prevention and treatment of post partum hemorrhage.
2. Discuss management of placenta praevia: (a) Centralis; (b) Marginalis.
3. Give symptoms, causes and treatment of tubal pregnancy.
4. Give etiology, symptoms and treatment of femoral thrombophlebitis.
5. An eight month pregnant patient shows albumin in the urine and a beginning hypertension—discuss management.

SURGERY

1. Illustrate by diagrams the positions of the bone fragments in (a) Colles's fracture; (b) Pott's fracture; (c) Intracapsular fracture of the hip.
2. Discuss briefly the important factors in the pre- and post-operative care of a patient who has acute intestinal obstruction.
3. (a) Discuss the diagnosis and management of carcinoma of the rectum. (b) Give its zones of spread. (c) Describe briefly the operation usually performed in the hope of a permanent cure.
4. What congenital anomalies of the heart and the great vessels in the thorax are amenable to surgery? Discuss the physiological objectives of operations for anyone of these defects.
5. A boy, fourteen years of age, comes to the hospital in moderate collapse after a coasting accident. He complains of pain on breathing and tenderness over the left tenth rib in the axillary line. Discuss the differential diagnosis and the treatment.

SPECIALTIES

1. Give the differential diagnosis between dermatitis venenata, dermatitis medicamentosa and urticaria.
2. A married man, 36 years of age, presents himself with a raised reddened, infected papule on his upper lip. What procedure would you follow?
3. Describe the chief functions of the nose.
4. **True or false:**
   (a) The canal of Schlemm empties under the middle turbinate bone of the nose.
   (b) The plexus of Stensons is adjacent to the rods and cones.
   (c) The nose is lined with ciliated columner epithelial cells.
   (d) Repeated ear infections is a cause for tonsillectomy.
   (e) The nasal vein empties into the angular vein which in turn empties into the superior ophthalmic vein.
5. Discuss the causes for finding pus in the urine and their treatment.

PREVENTIVE MEDICINE AND HYGIENE

1. Discuss amebic dysentery as to etiology, carriers, immunity, prophylaxis and prevention.
2. Discuss impetigo, its etiology, prophylaxis and eradication.
3. What is the period of incubation, the period of infectivity and the resultant immunity in: (a) diphtheria; (b) scarlet fever; (c) pertusis; (d) smallpox.
4. What is ophthalmia neanatorum—its causes, care, handling, prevention and dangers?
5. Draw a sketch of plan for private sanitary system of sewage disposal, noting distances important as to water supply, neighbors and ultimate disposal of effluence.

Ohio Nurses' Association Elects Officers

At the 47th Annual Convention of the Ohio State Nurses' Association the following officers were elected: Mrs. Ivalu S. Brown, Dayton, president; Marjorie Patten, Cleveland, 1st vice-president; Lucile Pence, Columbus, 2nd vice-president; Elizabeth A. Evans, Youngstown, secretary; Mrs. Florence Fogle, Columbus, treasurer. The following were elected to the Board of Trustees: Mrs. Edna W. Viets, Youngstown; Mrs. Helen D. Leiser, Fremont; Frances H. Cunningham, Cleveland; and Helen Gilligan, Columbus.

Breast Cancer Film Available to Medical Societies for Preview

A new movie, "Breast Self-Examination," a film to teach women the techniques of breast self-examination, is now available for distribution to professional groups only. It later will be released for showings to lay audiences.

Dr. Walter B. Lacock, chief of the Division of Chronic Diseases of the Ohio Department of Health, said that it is the desire of the sponsoring agencies to have this film shown only to medical and other professional groups until it can be properly appraised by them. He indicated that necessary clearances should be obtained through medical societies before the educational device is presented to the public.

The film has been tested before a number of different audiences and the consensus has been that great care has been taken to obtain the proper level of esthetic values and dignity.

The film is produced by the American Cancer Society and the National Cancer Institute. It is for 16 mm. projectors in color with sound and has a running time of 15 minutes. It is available to medical societies through the Ohio Division, American Cancer Society, 2073 E. Ninth St., Cleveland, or the Ohio Department of Health, Columbus.

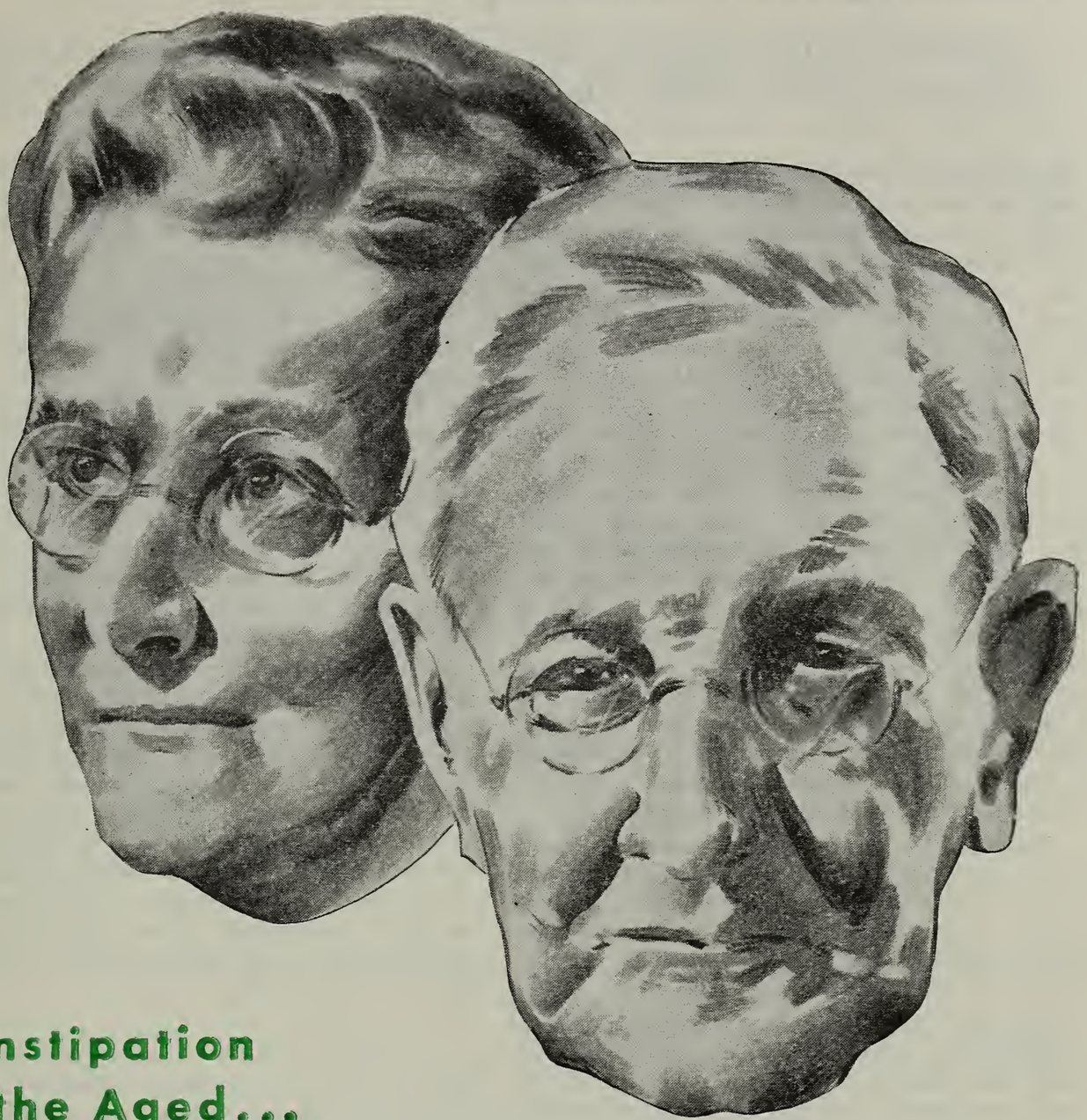
Other films available through the same agencies on the subject of cancer include: "The Problem of Early Diagnosis"; "Breast Cancer"; and "Science Against Cancer." These three are educational films for professional use.

Tuberculosis Association, Trudeau Society, Elect Officers

Officers of the Ohio Tuberculosis and Health Association for the year include the following: Dr. Azel Ames, Hamilton, president; Dr. Joseph B. Stocklen, East Cleveland, first vice-president; Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, Columbus, secretary. Dr. Herman J. Nimitz, superintendent of Dunham Hospital, Cincinnati, was elected a member of the executive committee.

The Association celebrated its 49th anniversary on June 1-2 with an annual meeting in Columbus. Actually three meetings were held—the Ohio Conference of Tuberculosis Secretaries and the Ohio Trudeau Society held concurrent meetings with the Association.

Dr. John A. Prior, Columbus, was elected president of the newly organized Ohio Trudeau Society. Dr. William Newcomer, Youngstown, was elected vice-president, and Dr. Chester R. Markwood, Columbus, secretary-treasurer. Members of the executive committee are Dr. Stocklen, Dr. James F. Busby, Newark, and Dr. John H. Skavlem, Cincinnati.



Constipation in the Aged...

The commonly encountered constipation of the older age group may result from reduced activity, lack of appetite for bulk-producing foods and inadequate ingestion of fluids.

By providing hydrophilic "smoothage" and gently distending bulk, Metamucil encourages normal physiologic evacuation without straining or irritation.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

METAMUCIL® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. G. D. Searle & Co., Chicago 80, Illinois.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Washington Roundup . . .

A Review of Developments on Proposed Medical and Health Legislation Before Congress; With Observations on Other Matters of Interest

ANOTHER victory for the medical profession was realized in Washington when the House of Representatives on July 10 voted down the President's Reorganization Plan 27 by adopting a resolution vetoing the plan. In a surprise move on the part of the Administration, the President on May 31 sent to Congress his plan which would have created a Department of Health, Education and Security. The plan would have become law within two months with no other action being taken. However, the medical profession went into action to make sure the plan did not "sleep through" into law. Medical organizations throughout the Nation alerted their Congressmen to what was going on.

A majority of the members of either house was required to defeat the plan. Because many members of the House were not present, the vote against the plan of 31 more than the necessary constitutional majority was misleading. Actually, of 322 members present, 249 voted against, 71 for, and two did not vote.

The plan was practically the same as Reorganization Plan 1 similarly defeated last year. It would have subordinated health and medical matters under a department which would have been virtually a welfare department, presumably with Oscar Ewing as its head.

Fourteen Ohio Representatives in Congress voted for the resolution which killed Plan 27. They are Congressmen Elston, Breen, McCulloch, Clevenger, Polk, Brown, Jenkins, Brehm, Vorys, Weichel, Secrest, Hays, McGregor and Young. They deserve the thanks of members of the medical profession.

Five Ohio Representatives voted against the resolution and for Plan 27. They are Burke, McSweeney, Kirwan, Feighan, and Crosser. Not voting or paired were Wagner, Smith, Huber and Bolton.

* * *

Department of Commerce officials are enthusiastic over the cooperation they are receiving on the survey of physicians' incomes. This survey is being made by the Office of Business Economics in cooperation with the Bureau of Medical Economic Research of the A. M. A. Although those interested in the survey believe it will be the most accurate ever made, one note of apprehension has been sounded. There is a possibility that physicians who have bookkeeping or clerical help, and therefore probably those in the higher income brackets, will likely send in the forms, while those without such help are more likely to neglect them. This could make the average appear higher than it actually is.

* * *

In analyzing a report prepared for it by the Veterans Administration, the American Legion reached the conclusion that only 19 per cent of V. A. hospital cases are strictly non-service connected. It reports that 81 per cent of all V. A. hospital patients fall into the following classes: (1) Established service-connected illness or injuries; (2) have at one time or another applied for pension or service-connected certification; and (3) are eligible to apply for such certification for various reasons, principally because they are mental cases.

This analysis is in conflict with other studies of the V. A. hospital situation which place the percentage of non-service connected cases at 50 to 70 per cent. The Legion contends that many veterans, particularly mental and tuberculosis cases, are appealing from adverse rulings, and for this reason should not be listed as non-service connected cases. In addition, the Legion claims that experience shows many cases now considered non-service later will be added to compensation or pension rolls after more careful study of their claims.

* * *

A Federal Security Agency publication, Report No. 14 on Legislative Service, concedes that legislation for Federal aid to medical education is dead for this session of Congress. The report notes that the House Interstate and Foreign Commerce Committee voted to table H. R. 5940, the bill on which it had worked for six months, then scheduled hearings on a substitute bill (H. R. 8886) for August 8. This action, F. S. A. says "in effect tabled the bill for the remainder of this session." H. R. 8886 was introduced by Representative Andrew Biemiller (D.-Wis.), a strong administration supporter, the day after the Committee tabled H. R. 5940, and following an urgent request from the White House that the Committee report out a bill to aid medical education.

* * *

A House subcommittee, appointed to investigate activities of the Federal Security Agency, released its report late in June in which it describes the agency as inefficient, wasteful, overstaffed and engaged in outright and illegal propaganda in support of national health in-

AUREOMYCIN

CRYSTALLINE

in Infections of the Puerperium

During the past year, obstetricians have become increasingly impressed with the ability of aureomycin to prevent or arrest infections of the puerperium. Where infection is feared, or has appeared, this broadly effective antibiotic is highly useful. Drug fastness and allergy are very rare following aureomycin. It is believed that this new crystalline form of aureomycin obviates nearly all side reactions.

Aureomycin



Aureomycin has also been found effective for the control of the following infections:

Acute amebiasis, bacterial infections associated with virus influenza, bacterial and virus-like infections of the eye, bacteroides septicemia, boutonneuse fever, brucellosis, chancroid, Friedländer infections (Klebsiella pneumonia), gonorrhea (resistant), Gram-negative infections (including those caused by some of the coli-aerogenes group), Gram-positive infections (including those caused by streptococci, staphylococci, and pneumococci), granuloma inguinale, *H. influenzae* infections, lymphogranuloma venereum, peritonitis, pertussis infections (acute and subacute), primary atypical pneumonia, psittacosis (parrot fever), Q fever, rickettsialpox, Rocky Mountain spotted fever, sinusitis, subacute bacterial endocarditis resistant to penicillin, surgical infections, tick-bite fever (African), tularemia, typhus and the common infections of the uterus and adnexa.

Capsules:
Bottles of 25, 50 mg. each capsule.
Bottles of 16, 250 mg. each capsule.

Ophthalmic:
Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

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surance. Representative John Bell Williams, a Mississippi Democrat, is chairman of the subcommittee.

Here are some of the findings of the subcommittee:

1. "Many if not all these shortcomings and discrepancies" are known to top Federal Security Agency officials. Some of the officials do not act to correct shortcomings because they "are wary of making decisions that will reduce employment or incur the ill will of a colleague or of a particular group with whom they disagree." Other executives are "evasive and tend to defend the prevailing circumstances regardless of the preponderance of evidence to the contrary."

2. The Federal Security Agency is relying heavily on the C. I. O. to help promote the President's health programs, and "documentary evidence secured in the agency reveals that some of the field service employees feel that a disproportionate part of their time is spent in public relations."

3. The Federal Security Agency does not need all of its 34,000 employees, many of whom are overpaid according to standards in other government departments; since 1940 Congress has voted four government pay raises, but F. S. A. personnel employees received average increases totaling $1,701 in excess of these standard increases.

4. "With few exceptions, the management improvement activities of the agency operate in an atmosphere of uncertainty. The various units are frustrated and disorganized. Under the present arrangement they are not producing in proportion to their cost." In several divisions, "the proportion of (purchasing) orders under $20 was more than 60 per cent, and the average cost of issuing each order was in excess of $10 . . . The average workload for each of the 197 persons engaged in processing procurement orders (in one office) was less than three per day (2.4) and half of them were for items costing less than $20."

* * *

Passengers on some buses and trolleys in Washington, D. C., have had to listen to "the added attraction" of radio programs. That might be bad enough, but sandwiched in the programs are plugs paid for by antivivisectionists such as this: "Beware, beware—your pets may wind up in vivisectional laboratories to suffer untold agony. Beware." When the District of Columbia Medical Society complained, they were told that the Agency would be glad to place a commercial for them on the buses and trolleys.

* * *

A full-scale investigation of the nation's food supply has been ordered by the House of Representatives, with particular attention to be devoted to determining the effect on foodstuffs of new chemicals and compounds. One area of the study will attempt to learn in what way if any atomic byproduct fertilizers affect crops. Attention will be given to possible harmful results from chemicals and synthetics used in production, processing and packaging of foods and the effect of pesticides and insecticides.

* * *

Dr. Dean A. Clark has been named to head the Senate Labor and Public Welfare subcommittee survey of voluntary health insurance plans. Dr. Clark, general director of the Massachusetts General Hospital, was in charge of the New York State Health Insurance Plan for four years. The committee must report its findings and recommendations to the Senate by February 1, 1951.

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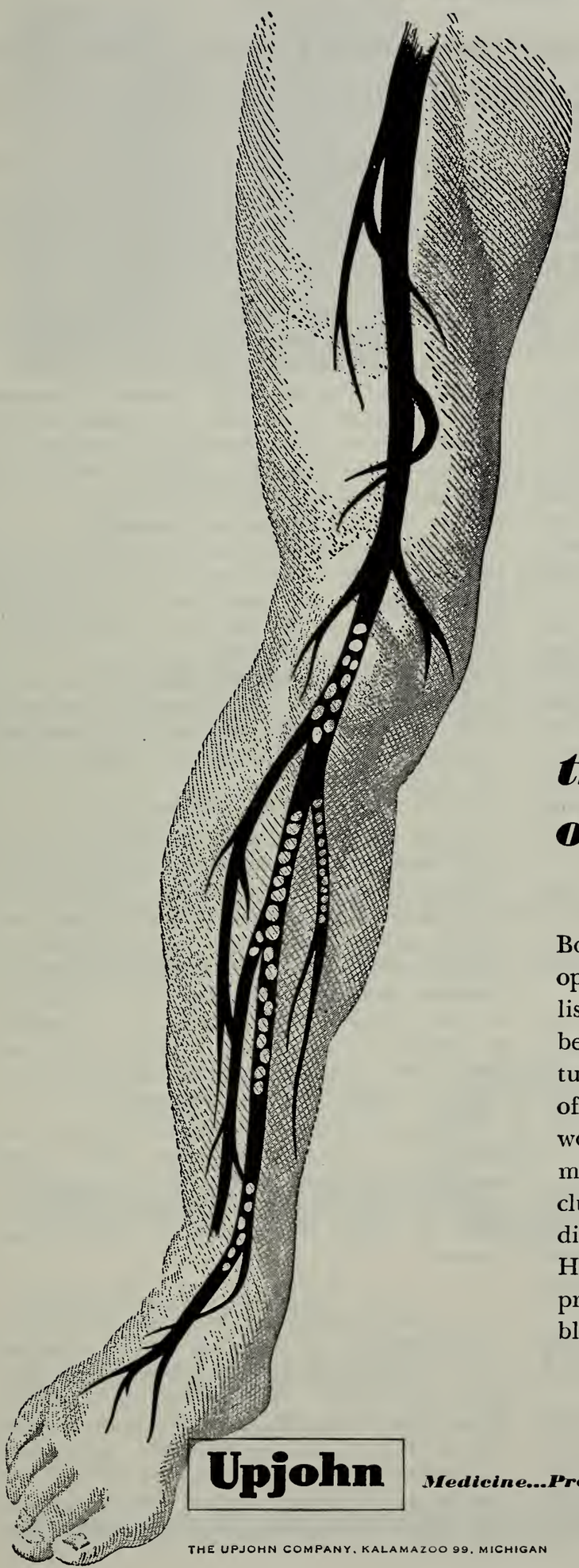
43 Life Insurance Companies Announced Increases in Fee Schedules

After considerable negotiating between the medical profession and life insurance companies, the Bureau of Medical Economic Research of the American Medical Association in mid-June reported that 43 companies have announced increases in their fee schedules. The report states that while the amount of increase in each case is not on record, in general the increase is 50 per cent across the board.

Following are the names of companies which the A. M. A. announced had raised their fees as of early June:

1. Aetna
2. American General
3. Bankers Life
4. Columbian National
5. Connecticut General
6. Connecticut Mutual
7. Continental Assurance
8. Control Life
9. Equitable Assurance, N. Y.
10. Equitable of Iowa
11. Fidelity Mutual
12. Franklin Life
13. Great Southern
14. Guardian
15. Home Life
16. Jefferson Standard
17. Life Insurance of Vermont
18. Lincoln National
19. Manhattan
20. Maccabees
21. Metropolitan
22. Mutual Life, New York
23. Mutual Trust
24. National Life & Accident
25. National Life, Vermont
26. New England Mutual
27. New York Life
28. Occidental
29. Ohio National
30. Pacific Mutual
31. Pan American
32. Phoenix
33. Pilot Life
34. Provident Mutual
35. Prudential
36. Security Mutual
37. Southland Life
38. Southwestern
39. Standard, Oregon
40. State Mutual
41. Sun Life
42. Travelers
43. United Life & Accident

The Arthritis and Rheumatism Foundation is offering fellowships for research in the basic sciences related to the study of arthritis. These fellowships carry a stipend of from $4,000 to $6,000. Applications should be sent to the Arthritis and Rheumatism Foundation, 535 Fifth Avenue, New York 17, N. Y., by January 1, 1951.



the probability of thrombi . . .

Both morbidity and mortality from postoperative venous thrombosis and embolism, frequent sequelae to surgery, have been dramatically reduced by early institution of anticoagulant therapy. Studies of anticoagulants by Upjohn research workers have led to the development of many Heparin Sodium preparations, including long-acting Depo*-Heparin Sodium, with or without vasoconstrictors. Heparin Sodium preparations provide promptly effective and readily controllable anticoagulant therapy.

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A. M. A. Annual Session . . .

Large Group From Ohio Attends Meeting in San Francisco Where House Of Delegates Transacts Many Items of Interest to Medical Profession

THE American Medical Association Annual Session in San Francisco, June 26-30, was one of the most successful on record, according to *The Journal of the A. M. A.* More than 25,000 persons, including 10,119 doctors, attended. Although the number of doctors who attended could not compare to attendances of meetings held in the populous East, officials were highly pleased with results.

Ohio doctors, reported in the official registration, numbered 250, an excellent attendance. A party of 95 Ohio doctors and members of their families went by special train which was arranged by the Headquarters Office of the Ohio State Medical Association. Accompanying this group were Mr. Charles S. Nelson, Executive Secretary, and Mr. George H. Saville, Public Relations Director.

The Ohio State Medical Association was represented by its eight delegates, Dr. Edgar P. McNamee, Cleveland; Dr. Carl A. Lincke, Carrollton; Dr. George A. Woodhouse, Pleasant Hill; Dr. William M. Skipp, Youngstown; Dr. L. Howard Schriver, Cincinnati; Dr. C. C. Sherburne, Columbus; Dr. Frank M. Wiseley, Findlay; and Dr. A. A. Brindley, Toledo. Dr. Paul A. Davis, Akron, was a delegate from the Section on General Practice.

Among doctors who served on reference committees were Dr. Lincke on the Committee on Amendments to the Constitution and By-Laws, and Dr. McNamee, chairman of the Committee on Insurance and Medical Service.

A detailed report on the meeting will be published in the September issue of *The Journal.* However, following is a summary of some of the highlights of the actions taken by the House of Delegates:

ACTIONS OF HOUSE

Authorized establishment of a Student American Medical Association, an organization for medical students; and in another action refused to support the Association of Interns and Medical students as presently constituted;

Adopted detailed reports by committees sent to Great Britain to study medical education and the practice of medicine in that nation;

Adopted a report of the Committee on Hospitals and the Practice of Medicine which denounces systems whereby hospitals hire salaried physicians for medical care and the hospitals bill the patients for this care, making a profit from the services of the physicians.

Resolved to continue support of the World Medical Association;

Criticised the practice prevalent in some hospitals whereby membership in a specialty board is made a requisite for appointment or advancement;

Approved continuation of the National Education Campaign during 1951 with the firm of Whittaker and Baxter as directors;

Authorized the Board of Trustees to proceed with expansion of the A. M. A.'s Department of Public Relations and expansion of special committees of the Council on Medical Service, in anticipation of eventual discontinuance of the special National Education Campaign;

Voted to provide each member with *The Journal of the A. M. A.*, starting in 1951 by including subscription to the magazine in membership dues and to set the dues for 1951 at $25—the same as the 1950 dues;

Referred to a committee study of the status of Fellowship with instructions for the committee to report at the December, 1950, meeting;

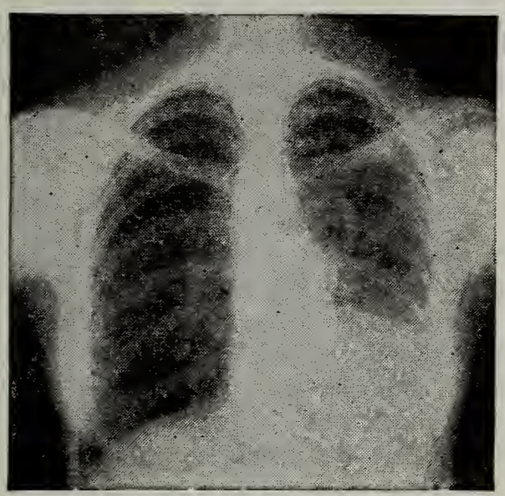
Chose New York City for the annual convention in 1953.

OFFICERS ELECTED

Among officers elected by the House of Delegates were Dr. John W. Cline, San Francisco, president-elect; Dr. R. B. Robins, Camden, Ark., vice-president; Dr. George F. Lull, Chicago, reelected secretary; Dr. J. J. Moore, Chicago, reelected treasurer; Dr. F. F. Borzell, Philadelphia, reelected speaker of the House; Dr. James R. Reuling, Bayside, N. Y., reelected vice-speaker. Dr. Elmer L. Henderson, Louisville, Ky., assumed office as president at the meeting to succeed Dr. Ernest E. Irons, Chicago.

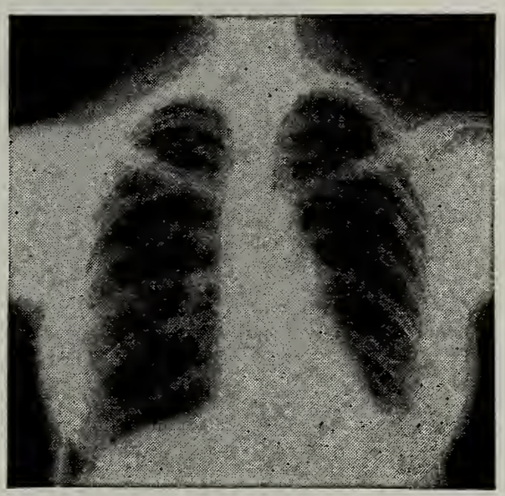
Dr. Leonard Larson, Bismarck, N. D., and Dr. Thomas P. Murdock, Meriden, Conn., were elected to the Board of Trustees to succeed Dr. John H. Fitzgibbon, Portland, Ore., and Dr. James R. Miller, Hartford, Conn., whose terms expired.

New applications for Research Fellowships and Established Investigators will be accepted by the American Heart Association up to September 15, 1950. Applications for Research Grants-in-Aid, including grants to basic sciences, may be filed up to December 15. Information and application forms may be obtained from Dr. Charles A. R. Conner, medical director, American Heart Association, 1775 Broadway, New York 19.



Before Treatment (*9 days prior to Dihydrostreptomycin therapy*) *Diffuse lobular tuberculous pneumonia, lower half of left lung; thin-walled cavity above hilus (3 x 3 5 cm.).*

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

DOCTORS AND THE PRESENT WAR EMERGENCY

Any attempt to surmise the part that the medical profession must play in the emergency would be premature as this issue went to press. The need for medical officers by the Armed Forces is becoming increasingly acute as the conflict in Korea progresses.

It may be recalled that for at least the last two years the Armed Forces, in cooperation with the Medical Profession, has been putting on a concerted drive for medical officers and thereby for the time forestalled a theatened draft of certain categories of doctors. It was revealed that Armed Forces, by sharply cutting back over the last year, had succeeded in establishing a "surplus" of doctors which acted as a cushion when the emergency broke out

Reactivation of the Selective Service act left the situation the same as it had been with regard to doctors—that is, only those doctors between the ages of 19 and 25, inclusive, can be drafted. This, of course, is subject to change by Congress.

With the authorized increase in the Armed Forces strength, the need for medical officers is paramount. Army, Navy and Air Force are calling for reserve officers to volunteer for active duty, but involuntary induction looms as a decided possibility.

The largest potential group of volunteers is made up of former Navy V-12 and Army A. S. T. P. medical students, who had all or part of their education financed by the government but were not required to serve on active duty because of termination of World War II. There is a potential of some 8,000 physicians and dentists in this group.

A second source are men deferred from the draft to complete their medical education at their own expense during World War II. No estimate of how many there are in this category has been made.

A third group of potential volunteers is composed of physicians who, for several years after the war, were assigned to residencies and internships on active duty status, but who were allowed to leave the service immediately upon completion of their training. This is a small group.

There are currently about 6,000 doctors in the three services, including men in training and serving internships and residencies. There are about 30,000 medical reserve officers.

The Army already has pulled an appreciable number of first and second year residents out of hospitals and sent them to duty with troops. Many young men who have just completed their internships under the Army civilian training program have already been sent to active duty. Several thousand reserve medical officers in all grades have received letters urging them to volunteer. The Navy and Air Force also are making similar efforts to fill their needs.

The President in his address to Congress and later to the public revealed that he had authorized the calling of reserves. The Armed Services immediately announced that limited numbers of reservists—primarily those with specialty training, including doctors—were being called to active duty.

FLORIDA COUNTY GOES ALL OUT IN EMERGENCY CALL SERVICE

In Florida perhaps a new high has been established in the emergency call service. The Escambia County Medical Society in cooperation with the District Nurses Association have established a 24-hour exchange which answers calls not only for doctors but for registered nurses, dentists, druggists, practical nurses, funeral homes, the American Red Cross and the Home Nursing Service.

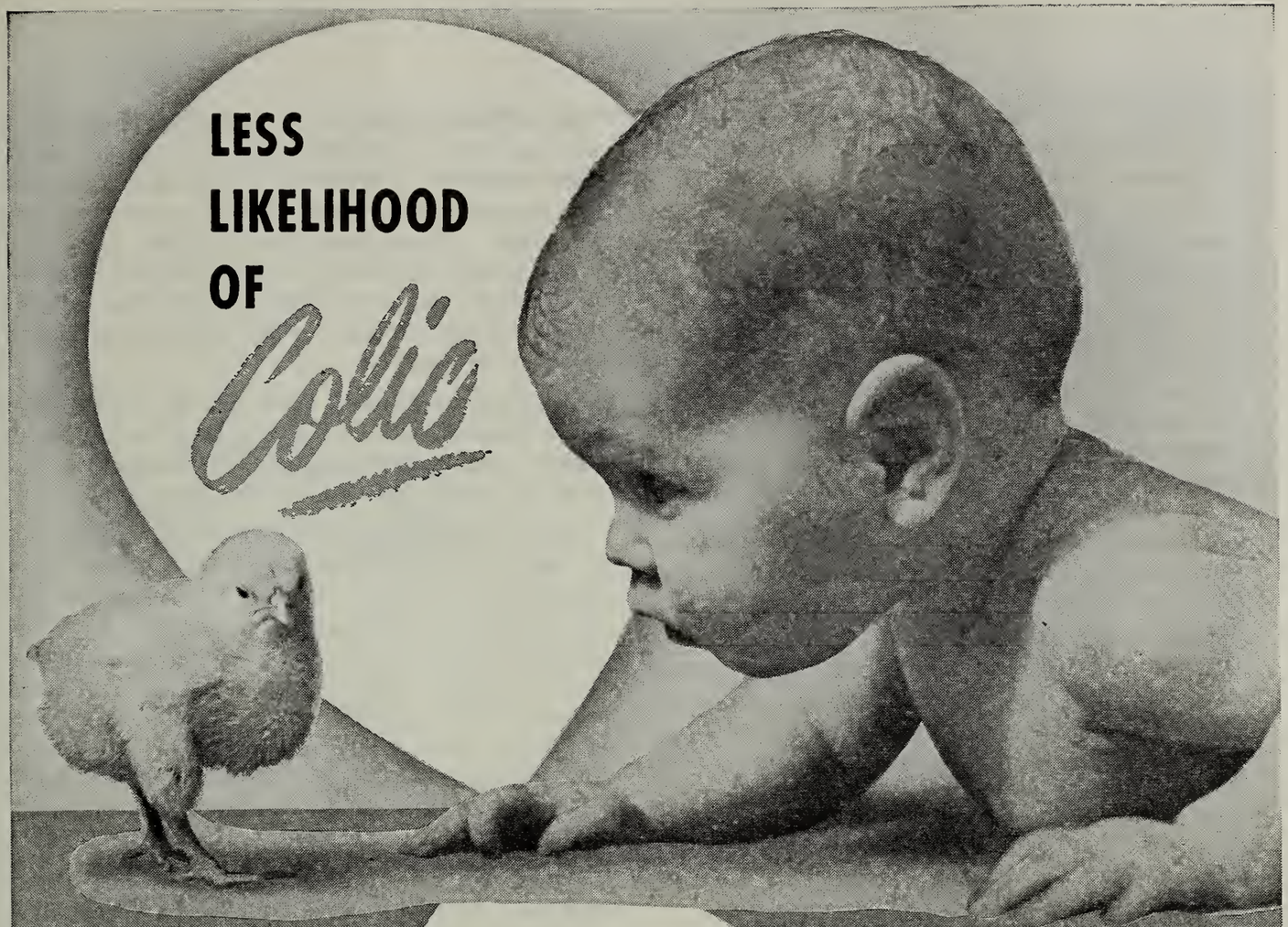
In reporting great initial success in the venture, local doctors stated: "We felt the need for a complete health center, where people in an emergency could get all types of medical aid immediately."

Whether or not the venture sets a precedent, the doctors of that Florida county are going all out to render a service to the public.

SOME HEALTHFUL THINKING ON THE PART OF HEALTH PERSONNEL

In a report of a change in policy as to distribution of Federal grant-in-aid funds to local health departments, Dr. Porterfield, director of the Ohio Department of Health, made a very significant observation.

"These factors are established," he said, "in accordance with the philosophy that support of local health units is primarily the respon-



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sibility of local government. They also prevent the conservation of local funds by substitution of Federal assistance."

That is healthy thinking from Ohio's health director. And as an indication that this kind of thinking is widespread among public health workers, Miss Elizabeth Lovell, director of Public Health Education of the North Carolina State Board of Health, spoke along the same lines at a recent Ohio Public Health Association meeting. Miss Lovell was speaking in terms of individual initiative on the local level. She pointed out the need to get the help of the people in the community. She further stressed the point that people in local communities can think for themselves, can discover problems for themselves and can do something about it on their own initiative.

When we have more public officials and people generally thinking in terms of local initiative to meet local needs, we won't have to worry so much about establishment of a push-button system in Washington.

IT ISN'T WHAT YOU SAY SO MUCH AS THE WAY YOU SAY IT

Nation's Business, in an article entitled, "Paging Joe Doakes, Capitalist," calls attention to the report that 78,000,000 people in this country have life insurance policies, nearly 60,000,000 have savings accounts, between 10,000,000 and 20,000,000 own stocks and about 55 per cent of the population own bonds.

This disclosure that the much-despised "capitalists" are numbered among almost every family in the nation is not news to the medical profession, but it does point up a problem in public relations.

Perhaps some of us in our enthusiasm to discredit the propaganda of the Communists and Socialists fail to spell out our ideas and ideals in terms that convey their real meanings to the people we eventually wish to influence.

Our talks before luncheon clubs and other organizations which comprise principally the executive class must have two-fold purposes—first, they must stimulate listeners to present a united front against the encroachments of "isms"; and, secondly, they must provide ammunition which these hearers can pass on to the masses who mark the ballots.

In our enthusiasm we talk matter-of-factly about the benefits of free enterprise, our capitalistic system and the Constitutional rights of individuals. Yet these, in the final analysis, are classroom terms, and may connote many meanings in the minds of those with limited educations.

Propagandists have carefully twisted the meanings of such terms until many a gullible person may have a grossly erroneous idea of what they represent. "Capitalism" very often connotes the concentration of capital in the hands of the few rich. "Free enterprise," in the minds of some, brings up visions of big business exploiting natural resources. The glorification of the individual may imply restrictions on the rights of labor to organize.

As a matter of fact, there are on record sufficient examples of abuses of these fundamental rights to give the propagandists ammunition to back up their undermining doctrines.

The Communists and Socialists are careful not to point out to the working man that he is a capitalist if he buys a bond or does anything else with his money except spend it. They do not admit that a worker is enjoying the free enterprise system when he quits one job and goes to one which offers more opportunity. They neglect to inform their listeners that the working man is enjoying the highest type of individual initiative when he can find the means and the will to send his youngster through college.

We would not for a minute advocate that speakers stoop to using a 500-word vocabulary or otherwise address audiences as though they were composed of morons. But each speaker would do well to consider that his expressed ideas go much farther than the immediate audience he is addressing. We want to reach the so-called intellectuals, but we want also to reach the working man, the farmer and the housewife. The great masses of these people think, but they think in terms of everyday living—and that's the level on which we must meet them.

THE SCOREBOARD IS USUALLY THE BEST INDICATION OF THE SCORE

Those skeptics, both in and out of the medical profession, who scoff at the profession's campaign to tell its side of the story to the public might take a look at the scoreboard as it is reflected in the public press.

Being skeptics perhaps they will see the one bad story and miss the 99 good ones, but if they have any sense of proportion they cannot miss the unprecedented interest the press is taking in medical and health matters.

Throughout the nation many newspapers are devoting whole sections to tell the story of medical progress during the past 50 years. In Ohio literally thousands of columns of type have been devoted to those doctors who have served their communities for 50 or more years. Other hundreds and perhaps thousands of columns have been devoted to medical and health matters from all angles.

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In Memoriam . . .

Harvey L. Basinger, M. D., Lima; Ohio State University College of Medicine, 1914; aged 59; died June 22; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Academy of Medicine of Lima and Allen County, 1950; its vice-president in 1926 and delegate to the Ohio State Medical Association in 1930. Dr. Basinger had practiced his profession in Lima continuously from the completion of his medical education, with the exception of the time he spent with the Naval Medical Corps during World War I. In addition to his medical affiliations, he was active in several Masonic orders and the Elks Club. Surviving are his widow, a son, a daughter, a brother and three sisters.

Benjamin Carlson, M. D., Lorain; Western Reserve University School of Medicine, 1925; aged 57; died June 16; member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1949; president of the Lorain County Medical Society in 1939. Dr. Carlson practiced medicine in Lorain for 21 years before retiring about a year ago. In addition to his professional work he was active in the College Club of which he was a former president and in the Congregational Church. Surviving are his widow, a son, three daughters, a brother and two sisters.

Julia M. Donahue, M. D., Massillon; Northwestern University Woman's Medical School, 1892; aged 83; died June 19; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Psychiatry and Neurology. A former medical missionary in China, Dr. Donahue was a resident physician at the Massillon State Hospital for 23 years and later was engaged in private practice. A veteran of World War I, during which she served with the Medical Corps, she was a member of American Legion Auxiliary. She also was a member of the Daughters of Union Veterans, Ladies of the G. A. R., Massillon Woman's Club and the Methodist Church. A brother survives.

Fred M. Douglass, Toledo; Toledo Medical College, 1911; aged 60; died July 4 on a return trip from the A. M. A. Annual Session in San Francisco; member of the Ohio State Medical Association and a Fellow of the American Medical Association; vice-president of the Academy of Medicine of Toledo in 1936 and its president in 1937; diplomate of the American Board of Surgery; member of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons; International College of Surgeons and the American College of Surgeons. Dr. Douglass had practiced in Toledo beginning in 1912 and had been chief of the surgical staff at St. Vincent's Hospital since 1926. He was a promoter of prepaid medical and surgical insurance in his area and was one of the founders of Ohio Medical Indemnity, Inc. He was a member of several Masonic Orders, the Elks Club, the Toledo Club and Inverness Club. Surviving are his widow; a daughter; a son, Dr. Fred M. Douglass, Jr., with whom he was associated in practice; a brother and a sister.

Roy P. Elder, M. D., Portsmouth; Ohio State University College of Medicine, 1910; aged 67; died June 12; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Hempstead Academy of Medicine, 1935. Dr. Elder was medical examiner for the N. & W. Railway. He was a member of the Masonic Lodge, the Elks Club and the Kiwanis Club. Surviving are his widow, a brother and a sister.

John L. Gates, M. D., Ann Arbor, Mich.; Ohio State University College of Homeopathic Medicine, 1917; aged 60; died June 15. Survivors include his widow, a son and a daughter.

Robert W. Hancock, M. D., Elyria; Indiana University School of Medicine, 1922; aged 53; died June 29; member of the Ohio State Medical Association and the American Medical Association; secretary-treasurer of the Lorain County Medical Society 1925-27. Dr. Hancock had had a long practice in Elyria where he was chief of the surgical staff of Elyria Memorial Hospital. A veteran of World War I, he was a member of the American Legion. He was affiliated also with several Masonic orders, and the Congregational Church. Surviving are his widow, a son, a daughter, a brother and a sister.

Frank E. Hart, M. D., Canton; Medical College of Ohio, Cincinnati, 1893; aged 77; died June 30; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Hart began his practice in 1893 and had been in Canton 44 years. In 1944 he was honored by his colleagues upon completion of 50 years of practice. Later he was awarded the 50-Year Pin and Certificate of the Ohio State Medical Association. He was a member of the Christian Church and the Masonic Lodge. Surviving are a daughter, a son and a brother.

James R. Hilling, M. D., Lucasville; Hospital College of Medicine, Louisville, Ky., 1905; aged 72; died June 18. Dr. Hilling practiced in Middletown before moving to Lucasville 15 years ago. Surviving are his widow, two daughters, a brother and a sister.

John Scudder Hull, M. D., Hicksville; Eclectic Medical College, Cincinnati, 1896; aged 77; died

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July 2; member of the Ohio State Medical Association and a Fellow of the American Medical Association; vice-president of the Defiance County Medical Society, 1940-41, 1946-48, and president in 1942 and 1943. Dr. Hull had practiced continuously in Hicksville beginning in 1896 with the exception of time he spend in graduate study. Recently he was honored by the Defiance County Medical Society by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. He was a life member of the Methodist Church, and was a past master and 50-year member of the Masonic Lodge, within which he was affiliated with several orders. He was an organizer and director of the Hicksville Bank and a member of the Rotary Club. Surviving are his widow and a son.

Glover T. Keen, M. D., Cincinnati; University of Cincinnati College of Medicine, 1933; aged 52; died June 23; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Keen had practiced in Cincinnati since completion of his medical education. He was a member of the Smoke Abatement League of Cincinnati, Alpha Sigma Phi, McMillan Lodge, Masonic Lodge, Nu Sigma Nu and the Presbyterian Church. Surviving are his widow, a daughter, three sisters and a brother.

William N. Mundy, III, M. D., Toledo; Harvard Medical School, 1943; aged 32; died June 29 in a traffic accident while returning from a vacation trip in the East; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Mundy had been in practice for the past four years in Toledo where he was associated with his father. His wife and three children died with him in the accident. Surviving are his parents, Dr. and Mrs. Carll S. Mundy, of Toledo, and a sister.

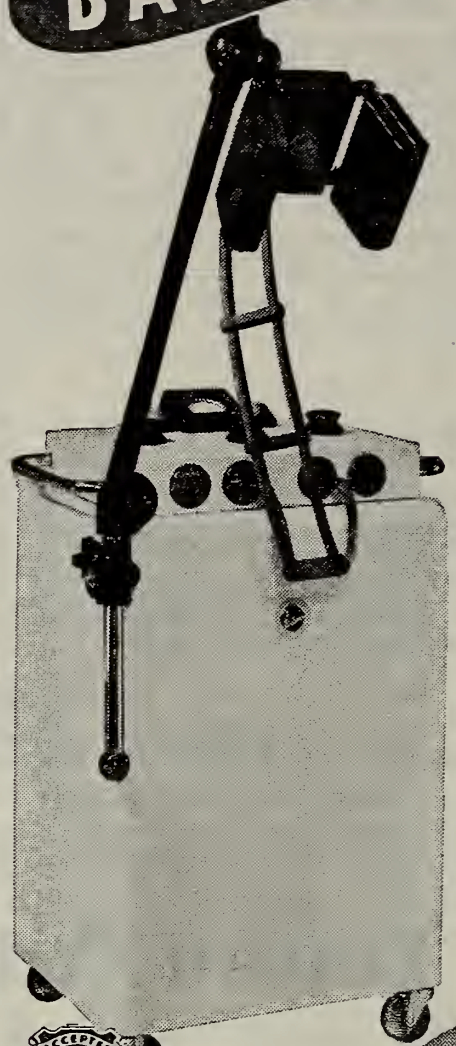
Charles A. Neal, M. D., Norwood; Medical College of Ohio, Cincinnati, 1907; aged 66; died June 13; member of the Ohio State Medical Association and the American Medical Association; member of the American Public Health Association. Dr. Neal, associated with the Veterans Administration in Cincinnati, was formerly superintendent of the Hamilton County Home and Chronic Disease Hospital. He served as Hamilton County health commissioner from 1923 to 1929 and as director of the Ohio Department of Health in 1929 and 1930. He was a member of the Catholic Church. His widow survives.

Benjamin C. Simmons, M. D., San Antonio, Texas; University of Cincinnati College of Medicine, 1923; aged 59; died July 3; former member of the Ohio State Medical Association through 1942. Dr. Simmons retired in 1942 because of

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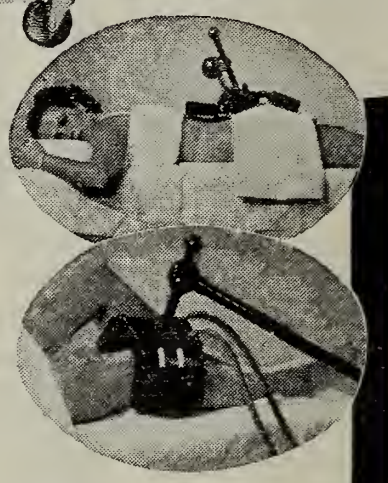
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ill health after practicing in Cincinnati for 20 years. Two daughters and a son survive.

Marcus O. Smith, M. D., Porterville; Starling Medical College, Columbus, 1891; aged 87; died June 10; member of the Ohio State Medical Association and the American Medical Association through 1945; president of the Perry County Medical Society in 1928. Dr. Smith had practiced medicine for 57 years, virtually all of that span in Perry County. Recently he was presented the 50-Year Pin and Certificate of the Ohio State Medical Association. Surviving are his widow, three daughters and a brother.

James C. Steiner, M. D., Willard; Ohio State University College of Medicine, 1923; aged 62; died June 30; member of the Ohio State Medical Association and a Fellow of the American Medical Association; secretary-treasurer of the Huron County Medical Society in 1934 and its delegate in 1939. Dr. Steiner had practiced in Willard for 27 years and was associated recently in practice with his son-in-law, Dr. Walter A. Drury. He was a member of the Evangelical United Brethren Church and the Rotary Club. Survivng are his widow, two daughters, two sisters and three brothers.

John T. Stonerock, M. D., Union; Eclectic Medical College, Cincinnati, 1894; aged 78; died June 18. Dr. Stonerock had practiced in the Union vicinity for 56 years. Surviving are his widow, two daughters, three sons.

William I. Waters, M. D., Midland, Texas; Ohio State University College of Medicine, 1937; aged 37; died June 26 as the result of a traffic accident; member of the State Medical Association of Texas and a Fellow of the American Medical Association.

Charles N. Watkins, M. D., Fort Recovery; Ohio Medical University, Columbus, 1904; aged 73; died June 19; former member of the Ohio State Medical Association through 1921. Surviving are his widow, a son, a daughter, a sister and a brother.

Windsor Offers Two Residencies

In the article on "Hospital Training Facilities," June issue of *The Journal*, the Windsor Hospital, Chagrin Falls, was erroneously listed under Cleveland Hospitals, and may have been missed by some readers. The Windsor Hospital is approved by the Council on Medical Education and Hospitals of the A. M. A. for two residencies in psychiatry.

Dr. L. M. Otis, Celina, was winner of the Maturity Event of the A. M. A. golf tournament held at the annual session in San Francisco. There were 311 doctors who participated in the tournament. The winning scores were 37, 37, 38 and 41.



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Buckeye News Notes . . .

Ashland—Dr. A. D. Robertson was elected president of the newly organized Ashland County Mental Hygiene Association. Dr. C. B. Meuser and Dr. Wayne C. Smith were among persons elected to board of directors.

Canton—Shortcomings of British socialized medicine were discussed by Dr. Scott E. Hill before the Optimist Club.

Cincinnati—Dr. Stanley E. Dorst, dean of the University of Cincinnati College of Medicine, spoke on "Medical Education and Practice in Great Britain" at a special meeting of the Public Health Federation in Hotel Gibson.

Cleveland—Dr. Richard R. Renner was named Disciple of the Year by the Cleveland Disciples Union, for outstanding service to local, state and national work for the organization.

Cleveland — Dr. Middleton Lambright, Jr., presented papers on "The Management of Gynecological Infection" and "Diagnosis of Lung Cancer" at the Lone Star State Medical Convention.

Columbiana—Dr. C. W. Dewalt was guest of honor at a meeting sponsored by the Kiwanis Club. He was cited for these accomplishments among others—former mayor of Columbiana, instigator of the sanitary sewer system in the city, president of the county board of health, president of the Columbiana County Medical Society, chief of staff at Salem City Hospital, and a charter member of the Kiwanis Club.

Columbus—Dr. Allan C. Barnes, Ohio State University College of Medicine, addressed the Rotary Club on the subject, "Medical Education."

Grover Hill—Dr. T. P. Fast was honored at a public gathering sponsored by the Lions Club for his long service to the community. He has practiced in Grover Hill since 1900.

Marietta—Dr. Harry W. Hill, of Vincent, was the subject of a human interest article in the *Marietta Times*. Although past 80, he is still in active practice and for 25 years has been president of the Washington County Board of Health.

Painesville—Dr. John W. Davis is the new Lake County health commissioner. He succeeds Dr. W. H. Willis who resigned.

Rio Grande—Dr. Charles E. Holzer, Sr., Gallipolis, resigned as chairman of the board of trustees of Rio Grande College after holding that office since 1922. He was reelected as a member of the board.

Sandusky—Dr. Ross M. Knoble spoke on the subject of "Socialized Medicine" before the Junior Chamber of Commerce.

Wooster—Dr. E. E. Judd spoke on the subject of "Socialized Medicine" before the Minute Women of Ohio, Wooster Chapter.

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Do You Know? . . .

Guest speakers at the 83rd Annual Meeting of the West Virginia State Medical Association, July 27-29, at The Greenbrier, White Sulphur Springs, included: Dr. George M. Curtis, Dr. Allan C. Barnes, Dr. Earl H. Baxter, Columbus, and Dr. A. William Friend, Akron.

* * *

Under the direction of the Cleveland Ophthalmological Club, a group of Cleveland oculists and opticians has presented Western Reserve University School of Medicine with a gift of $10,000 for the establishment of a special laboratory of ocular physiology in the Department of Physiology.

* * *

Dr. Harry V. Paryzek, General Chairman of the Local Committee on Arrangements for the Annual Meeting of the Ohio State Medical Association in Cleveland last May, who was unable to participate in the meeting because of illness, has completely recovered and returned to active practice.

* * *

Dr. Edward J. McCormick, Toledo, a member of the Board of Trustees of the American Medical Association, has been named by the Board as a member of the Coordinating Committee on the National Education Campaign. His other assignments include: Chairman of the Committee on Scientific Exhibit and representative of the Board to the Council on Industrial Health.

* * *

A graduate of the University of Cincinnati College of Medicine in 1937, Dr. Francis M. Forster, Philadelphia, has been appointed professor of neurology and director of the department at Georgetown University School of Medicine.

* * *

Physicians who registered at the White Laboratories booth in the Technical Exhibit at the A. M. A. meeting in San Francisco were given a chance on a brand new Cadillac club coupe. The lucky winner was Dr. Edgar P. McNamee, Cleveland, one of the Ohio delegates.

* * *

There were 1,697 traffic deaths in Ohio during 1949. Of these, 767 or 45 per cent, occurred as a result of accidents on rural state highways.

* * *

Western Reserve University School of Medicine has received a grant of $15,000 toward investigation in the field of surgery to increase the blood supply to the brain of retarded children. Dr. Claude S. Beck and Dr. Charles F. McKann have been doing research in this field. The grant, part of a total of $280,000 for research on infants and children's diseases and disorders, was made by Playtex Park Research Institute, sponsored by International Latex Corporation.

* * *

According to a report in the public press, the late Dr. Paul H. Krebs left a fortune of more than $1,234,000 to Lutheran Hospital, Cleveland. Dr. Krebs, a bachelor, practiced for 54 years from the same office in Cleveland.

* * *

The Central Ohio Heart Association has elected Dr. R. W. Kissane as its president for another year. Other officers include: Dr. G. I. Nelson, vice-president; Dr. Donald L. Mahanna, secretary; all are of Columbus.

* * *

Dr. Joseph H. Barach of Pittsburgh, Pa., spoke on the subject of diabetes at a meeting in the Cleveland Health Museum sponsored by the Cleveland Diabetes League.

* * *

For their research work with Compound E, Western Reserve University awarded honorary degrees of Doctor of Science to Dr. Philip S. Hench and Dr. Edward C. Kendall, of the Mayo Clinic, Rochester, Minn.

* * *

Dr. Leon Schiff, University of Cincinnati College of Medicine, was one of 11 American doctors invited to speak at the International Symposium on Liver Diseases scheduled in London, England.

* * *

At the recent session of the House of Delegates of the California Medical Association a resolution was adopted requiring that the officers, employees and delegates of the Association must subscribe to an anti-Communist oath as a prerequisite to holding office, employment or a delegate's seat.

* * *

One of the branches of the British Medical Association is concerned about "frivolous and unjustified emergency calls." The local society has asked the B. M. A. "to take all steps to persuade the Ministry of Health to institute some machinery whereby a doctor can lay a complaint against a patient, and whereby some penalty can be imposed on that patient if his conduct be deemed unreasonable."

* * *

The American Roentgen Ray Society, under the presidency of Dr. U. V. Portmann of Cleveland, will hold its 50th Anniversary meeting in St. Louis, September 26-29. Further information may be obtained by writing to the Society at 20 N. Wacker Drive, Chicago 6.

Commitment To and Discharge From Lima State Hospital

Since physicians frequently are faced with the problem of what to do with the criminal psychopath, the following comments will be of primary interest to the medical profession. The comments were prepared by Dr. Ewing H. Crawfis, Cleveland, who also has a law degree, and were published in the *Bulletin of the Cleveland Mental Hygiene Association.*

1. **Thirty-Day Observation** Cases—Any one accused of crime and before the Courts—either on indictment or trial where insanity is set up as a defense, or where sanity is under investigation,—may be sent to Lima for 30 days observation. At the end of that time the patient is returned to the Court and a report is made.

This procedure is not used frequently in Cleveland, because there is a local psychiatric clinic opearted by the Court, but it is frequently used in the other counties of Ohio, where psychiatric facilities are not locally available.

2. **Where Insanity Is Found before Conviction**—The presumption here is, that the patient, being mentally ill, is not able properly to defend himself, and under such conditions the Court commits the patient to Lima, "until restored to reason." The patient when recovered, is returned to the jurisdiction of the Court, and may then be tried.

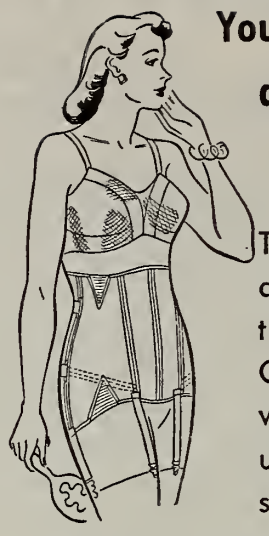
3. **Where Mental Illness Develops after Conviction**—Prisoners from the penitentiary or reformatories, who become mentally ill, may be transferred to Lima for treatment. Then, if recovery occurs:

(a) If sentence has expired before recovery, the patient is committed to the Lima State Hospital by the local Probate Court. Thereafter, the patient is considered as if he were committed to a Civil State Hospital, and if recovery occurs, trial visit and discharge are on the same basis.

(b) If recovery occurs while still under sentence, he is returned to the original institution.

4. **Dangerous Persons in Other State Hospitals, State Schools, or Institutions**—Where patients are considered dangerous and homicidal to such a degree that they are unmanageable in the local institution, they may be transferred to the Lima State Hospital. This is effected by a request to the Commissioner of Mental Hygiene, who authorizes such transfer. If recovery occurs, such patients are usually returned to the original institution for trial visit and discharge.

5. **Persons Previously Convicted of a Felony, who Become Mentally Ill**—The Probate Court may elect to commit a patient to Lima State Hospital, instead of to the Local State Hospital, if the patient has a record of conviction and is



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regarded as a dangerous person. Generally speaking, the courts do not do this, but commit the patient to the local hospital; transfer to Lima can be made as described in the previous paragraph, if the individual is found to be dangerous. Trial visit and discharge are the same in either of these procedures.

6. Persons Acquitted on the Ground of, "Not Guilty by the Reason of Insanity"—This is considered as a continuing insanity, and they are sent to the hospital automatically without the necessity of a finding, and commitment is prescribed under the law on such acquittal. There is special provision for discharge of such people after recovery. A committee of three, consisting of the Superintendent of Lima, the Judge of the Common Pleas Court of Allen County, and a psychiatrist as a third person, passes on whether the patient has recovered and can be discharged.

7. Psychopaths (the Aschermann Act) and a Number of Special Provisions for Commitment, as follows.—

(a) After conviction, but before sentencing, any felony except murder of the first degree (premediated).

(b) When diagnosis is established by a psychiatrist or a psychiatric clinic.

(c) When the Court imposes the appropriate sentence, it can then commit the patient to the hospital and suspend sentence.

(d) When the patient recovers or improves, so that further hospitalization is not indicated, one of two procedures occurs:

First, if the time spent in the hospital is less than the maximum sentence, the sentence goes into effect, and the patient is transferred to the appropriate penal institution. For parole purposes the time spent in Lima is counted as good behavior time.

Second, if the time spent is beyond the maximum sentence, then the sentence no longer applies and the patient may be placed on trial visit and discharged in the usual manner.

Dr. Meyer H. Fineberg, formerly on the faculty of Western Reserve University School of Medicine and a practicing physician in Cleveland, has been appointed manager of the Veterans Administration Hospital, Dwight, Ill. He has been with the hospital since 1946.

Many organization members throughout Ohio have heard inspiring talks by Dr. Christopher Daniels, London physician, who has been touring the country speaking on the evils of Socialism as it exists in England. His tour is under the auspices of Harding College of Searcy, Ark.

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GYNECOLOGY—Intensive Course, two weeks, starting Sept. 25. Vaginal Approach to Pelvic Surgery, one week, starting Sept. 18.

OBSTETRICS—Intensive Course, two weeks, starting Sept. 11.

MEDICINE—Intensive General Course, two weeks, starting Oct. 2. Gastro-enterology, two weeks, starting Oct. 16. Gastroscopy, two weeks, starting Sept. 11 and Oct. 23. Electrocardiography & Heart Disease, four weeks, starting Oct. 2.

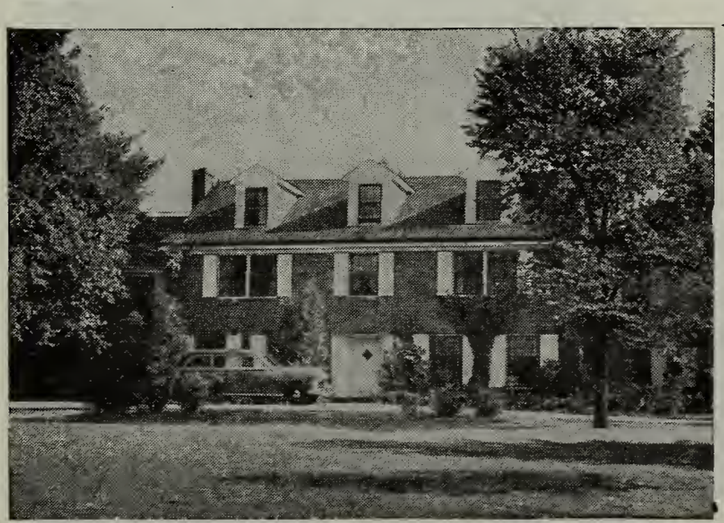
DERMATOLOGY—Formal Course, two weeks, starting Oct. 16. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, two weeks, starting Sept. 25. Cystoscopy, ten day practical course, every two weeks.

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Clark and Lake Counties Establish 24-Hour Emergency Services

Two more counties were added to the list of those which are offering the public 24-hour emergency call service when the Clark County Medical Society and the Lake County Medical Society announced opening of such services.

The Springfield News-Sun heralded the announcement of the Clark County Medical Society with a streamer head. More than 50 doctors in the Society have volunteered to cooperate in the call service, it was announced.

It was reported in the same announcement that Clark County physicians had for the past year given their services on a voluntary basis to man the emergency room at City Hospital in Springfield because of a shortage of interns and residents who usually cover that service.

In announcing the service, Clark County doctors specified some do's and don't's in regard to the service.

1. Call your family doctor first.
2. Be clear in giving the name and address of the patient.
3. Stay by your phone until contact has been made with the physician-of-the-day and you have been so advised.
4. Be calm and clear in answering questions by the operator.
5. Follow implicity any instructions given by attending physician.

1. Don't call the emergency medical service until you have tried to contact your family physician.
2. Don't use the service for general medical information.
3. Don't call for emergency medical service for persons intoxicated. The police should be called in such cases.
4. Don't abuse the service by calling when an emergency does not exist..

In Lake County the emergency call service was first put into effect over the 4th of July week-end. Early reports were that the service was working well but that at first few emergencies had developed.

Mrs. John Hurley is operating the Lake County call service for the Medical Society from her home in Painesville. Officials of the Society stated that practically all doctors of the county had signed up to participate in the service.

Dr. Evarts A. Graham, St. Louis, was selected for the annual Distinguished Service Award of the American Medical Association by the House of Delegates at the San Francisco meeting. Professor of surgery in Washington University School of Medicine and surgeon-in-chief of Barnes Hospital, Dr. Graham received world-wide recognition in 1933 when he performed the first successful operation for the removal of an entire lung.

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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

CLINTON

Dr. John H. Payne, Cincinnati, spoke on the subject, "Throat Conditions" at the June 6 meeting of the Clinton County Medical Society in Wilmington.

Dr. W. L. Regan, member of the building board, gave a report on the construction of the Clinton Memorial Hospital. Dr. E. K. Yantes, delegate, reported on the Annual Meeting of the Ohio State Medical Association held in Cleveland, May 16-18.

Meetings will continue through the summer, with the July meeting on the second Tuesday. The August meeting will be held at the Snow Hill Country Club.

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

MONTGOMERY

Officers elected to lead the Montgomery County Medical Society in 1951 were announced at the annual meeting on June 7, at the Biltmore Hotel in Dayton. They are Dr. Fred H. Miller, president-elect; Dr. T. L. Light, vice-president; Dr. R. E. Zipf, secretary; Dr. A. V. Black and Dr. W. K. Gregg, trustees for three-year term.

The new officers will serve with Dr. Harold M. James, elected to serve as president-elect during 1950 and who will take office as president at the first meeting in January, 1951.

Members of the Executive Council in 1951 will include the foregoing officers with Dr. H. D. Cassel as the immediate past-president; Dr. A. B. Brower as chairman of the past-presidents' committee, Dr. A. D. Cook, as trustee (term expires in 1951), and Dr. N. C. Hockwalt as trustee (term expires in 1952).

Also elected were the following who will take office in January, 1951: Dr. R. C. Doan, delegate, four-year term; Dr. Ned Shepard, alternate delegate, four-year term; Dr. W. R. Hockwalt, clinic committee, senior member, three-year term; Dr. R. P. Stafford, clinic committee, junior member, two-year term.

Delegates in addition to Dr. Doan are Drs. A. W. Carley, T. L. Light and R. D. Dooley. Alternate delegates in addition to Dr. Shepard are Drs. R. E. Pumphrey, L. E. Baker and J. M. Shaffer.

Serving on the Clinic Committee with Dr. W. R. Hockwalt and Dr. Stafford will be Drs. Paul Troup, chairman, E. F. Pfanner and W. A. Stowe.

PREBLE

Two Preble County doctors were honored by the Preble County Medical Society by being presented 50-Year Pins and Certificates of the Ohio State Medical Association. They are: Dr. G. W. Flory, of Eaton, and Dr. William J. Christian, of Verona. Dr. Merrill D. Prugh, Dayton, Councilor of the Second District of the Ohio State Medical Association, made the presentation to Dr. Flory at a meeting of the Society on July 31, and to Dr. Christian at his home.

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

LAKE

The Lake County Medical Society is sponsoring a weekly consultation psychiatric service starting August 3 at the Lake County Memorial Hospital, Painesville. Dr. F. E. Merritt, assistant director at the Cleveland State Hospital, will be the psychiatrist in charge. Doctors of



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the Society will refer patients to him for examination.

On July 19, the medical staff of the Lake County Memorial Hospital held its annual dinner meeting at the Madison Golf Club, with outdoor events scheduled for doctors and their wives. Dr. Allan Moritz, head of the Department of Pathology, Western Reserve University College of Medicine, spoke on the subject, "The Unexplained Death." Some of the county public officials were guests at the meeting.—Frederick J. Dineen, M. D.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

MAHONING

Dr. Louis H. Clerf, of Jefferson Hospital, Philadelphia, Pa., discussed bronchoscopy at the June 20 meeting of the Mahoning County Medical Society in Youngstown. Dr. C. A. Gustafson, chairman of the health education committee, presented awards to winners in the contest. Details of this essay contest were given in the June issue of *The Journal.*

TRUMBULL

More than 50 members of the Trumbull County Medical Society assembled for the monthly meeting at Packard Electric Division of General Motors Corporation, on June 21, as guests of the Company with Mr. B. N. MacGregor, general manager, and Dr. G. A. Sudimack, medical director, as hosts.

Following dinner and a tour of the plant, the group heard a panel discussion on industrial medicine with the following panel discussants: Dr. M. J. Drow, Dr. F. C. LaCamera, Dr. J. M. Glendhill and Mr. B. N. MacGregor. Dr. Sudimack acted as moderator. At the conclusion of the panel discussion, Mr. MacGregor presented a talk entitled, "An Industrialist Looks at Medicine."

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

The Belmont County Medical Society in April approved establishment of a travelling epilepsy clinic in the county. At the same meeting members heard reports by Dr. Fred Southerland, Martins Ferry, and Dr. L. D. Covert, Bellaire, on recent visits to the New Philadelphia cancer diagnostic clinic.

Dr. James J. Arbaugh presided at a scientific program at which Dr. Harry G. Harris, Martins Ferry, and Dr. L. L. Liggett, St. Clairsville, presented discussions. Three newcomers to the county were introduced. They are Dr. Julius

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Eighth District

(COUNCILOR: CHESTER P. SWETT, M. D., LANCASTER)

GUERNSEY

A special meeting of the Guernsey County Medical Society was held at the Cambridge State Hospital on July 6, immediately following the Woman's Auxiliary picnic, held by invitation of Supt. and Mrs. Arthur T. Hopwood. Dr. Reo Swan was in charge.

A bounteous repast was served by the Auxiliary with Mrs. W. L. Denny as chairman. Sixteen members and their wives were present; also several guests and children.

Memberships of two doctors were approved by vote. They are Dr. Howard Van Noate and Dr. Elizabeth Smith.—Gordon Lawyer, M. D., Secy.-Treas.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

MEIGS

Members of the Meigs County Medical Society and the Auxiliary were guests of Dr. and Mrs. E. F. Maag at their summer lodge on the Ohio River at Long Bottom. The occasion also marked the 30th anniversary of Dr. Maag's medical practice. A fish and picnic supper was served.

Urology Awards

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of some clinical or laboratory research in Urology. For full particulars write the Secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, New Jersey. Essays must be in his hands before February 10, 1951.

Woman's Auxiliary . . .

By MRS. S. L. MELTZER, Chairman, Publicity Committee
2442 DORMAN DRIVE, PORTSMOUTH

President—Mrs. George W. Cooperrider, 1828 Bryden Road, Columbus

President - Elect — Mrs. Farrell Gallagher, 1527 W. Clifton Blvd., Lakewood

Vice-President—Mrs. E. P. Greenawalt, 1707 St. Paris Road, Springfield

Recording - Secretary — Mrs. Ross Knoble, 219 - 44th St., Sandusky

Corresponding Secretary — Mrs. Oscar Jepsen, Canal Winchester

Treasurer — Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo 13

Past-President—Mrs. C. W. Kirkland, 4805 Guernsey Street, Bellaire

Numerous inquiries have been directed to officers about the Nurses' Loan Fund and who might be contacted for information about it. The chairman of the Nurses' Loan Fund is Mrs. Lewis B. Stephen, 207 E. College St., Oberlin.

DELAWARE

Mrs. James G. Parker entertained the members of the Woman's Auxiliary to the Delaware County Medical Society at her summer residence on June 13. Mrs. Harold W. Davis, the outgoing president, and Mrs. A. R. Callander, the incoming president, reported on the state auxiliary convention in Cleveland. The historian, Mrs. George Parker, gave her annual report. It was announced that Mrs. Davis would be one of Ohio's delegates at the national auxiliary convention in San Francisco. A "pot luck supper" was served on the enclosed porch of the Parker residence overlooking the Scioto River.

JEFFERSON

The Jefferson County Auxiliary, at its luncheon meeting on June 13 at the Steubenville Country Club, elected its new officers for 1950-51. They include: Mrs. Frank Harris, president; Mrs. J. A. Haney, president-elect; Mrs. Robert Puncheon, Jr., vice-president; Mrs. Albert Sunseri, secretary; Mrs. Stephen Hadobas, treas-



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urer, Mrs. Fred Harrington, corresponding secretary. The meeting was conducted by Mrs. David Greenberg in the absence of the retiring president, Mrs. Walter Cunningham. The nominating committee consisted of Mrs. Stanley Burkhardt, chairman; Mrs. S. L. Greenburg and Mrs. L. J. Kerschgens.

Games were played, following the business session. The social committee was headed by Mrs. Albert Sunseri. Assisting her were Mrs. Ernest Perri and Mrs. F. B. Harrington.

LUCAS

Mrs. Bernhard Steinberg was elected president of the Toledo and Lucas County Auxiliary at its annual luncheon on May 23 at the Toledo Country Club. Other officers elected were: Mrs. Hazen L. Hauman, president-elect; Mrs. Norman K. Foley, vice-president; Mrs. Maurice A. Schnitker, recording secretary; Mrs. B. V. Scheib, corresponding secretary; Mrs. John Dickie, treasurer; and Mrs. Joseph Hertzberg, assistant treasurer.

A talent and hobby show followed the business session. Mrs. Charles A. Phillips was chairman of the show and Mrs. Robert B. Curl, co-chairman. Antiques, quilts, needlepoint, glass, bottle collections, copper, autographs, buttons, pewter and Oriental carvings were among the many items exhibited. Ribbon awards were made for each class of the exhibit. Following the luncheon, Alice E. Huebner gave a book review.

MEIGS

Members of the Woman's Auxiliary to the Meigs County Medical Society were guests of Mrs. F. M. Cluff in May when a luncheon was held at the Little House, preceding the business meeting at Mrs. Cluff's home. Mrs. E. F. Maag, president, presided. Mrs. J. J. Davis presented her paper on "The Origin of the Woman's Auxiliary to the American Medical Association." The hostess' two daughters played a piano duet.

The June meeting of the Meigs County Auxiliary was high lighted by a picnic and fish fry at the country home of Dr. and Mrs. E. F. Maag when the latter couple was host to the doctors and their wives. The occasion also marked the thirtieth anniversary of Dr. Maag's medical practice. There was a surprise celebration, at which Dr. Kathryn Poindexter and Mrs. D. B. Hartinger gave tributes to Dr. Maag—Dr. Poindexter recalling incidents of his early life and Mrs. Hartinger concerning his early practice in Middleport.

SCIOTO

The Country Club provided an attractive background for the June guest day luncheon and get-together of the Scioto County Auxiliary. Mrs. Clyde Everett, the new president, dispensed with the usual business session, to allow for a program of special entertainment. Roses

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and daisies "rambling" along the luncheon tables proved a striking decoration feature. Fifty-three members and guests witnessed an unusual hat style show—the hats being made entirely of items purchased in the hardware store. Taking part in the hat style parade were Mrs. Everett, Mrs. L. B. Hatch, Mrs. George Obrist, Mrs. Alden Oakes, Mrs. S. L. Meltzer.

Miss Jean Kline and Mr. Howard Smith, professional entertainers, presented a rollicking song-and-dance act. Mr. Smith also played his accordion in leading the members in an old-time song-fest. Members of the committee on arrangements included: Mrs. Dow Allard, Mrs. Jack Herbert, Mrs. W. E. Gault, Mrs. Obrist, Mrs. Meltzer, Mrs. Hatch. A special group of guests was that of war brides from several foreign countries.

Opinions of the Attorney General

Following are the syllabi of opinions recently made by Attorney General Herbert S. Duffy:

Opinion No. 1946—The Board of Embalmers and Funeral Directors of Ohio may not delegate authority to an outside private investigator to make an investigation and arrest.

Opinion No. 1971—(1) Sec. 4036, General Code, cannot be read separate and apart from the other sections pertaining to the duties and powers of trustees of hospital funds. (2) The board of governors of a joint municipal-county hospital has no authority to accept or administer cash donated to the board for hospital purpose. (3) The board of governors of such a hospital has no authority to accept or administer donations given for specific purposes or for investment. These functions properly belong to the board of hospital trustees. (4) There is no authority permitting the merging of the board of hospital trustees with the board of governors. The composition and qualifications for membership in these boards differ and are incompatible due to diversity of method of appointment.

Opinion No. 1981—(1) Prosecuting Attorneys are the legal advisers to boards of county hospital trustees as established pursuant to Sec. 3131, G. C. (2) by virtue of Sec. 2917 G. C., boards of county hospital trustees are without authority to employ legal counsel. (3) Members of boards of county hospital trustees hold office of trust and as such become amenable to Sec. 12910, G. C.

English Newspaper Reports Revolt In National Health Scheme

An Ohio doctor forwarded to the Headquarters a copy of *The London Express*, the influential British newspaper founded by Lord Beaverbrook, in which it was reported that Britain's National Health Scheme is in revolt.

Three hundred doctors, representing the 19,000 members of the profession, met in London to threaten withdrawal from the scheme.

Dentists have already broken off wage negotiations with Health Minister Bevan, the *Express* reports.

Chemists (druggists) are pressing for improved rates of pay.

Doctors want another seven million pounds in the central pool. Some of them complain that they receive little more than 500 pounds a year.

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Employment of the Physically Handicapped

A great deal has been and is being written on the subject of employing the physically handicapped. The following facts on this subject published in *The Journal of the A. M. A.*, will be of interest to doctors.

It has been estimated that there are probably seven to eight million physically handicapped persons in the working population of the United States. About six million are said to be employed and a quarter of a million are either seeking work or can be rehabilitated and trained for work.

Some are said to be in jobs for which they are not best suited, and this provides a hardship for the handicapped and a burden for the employer, even the taxpayer. Obviously it can be a cause of considerable waste.

One of the solutions is better understanding and information, and attempts are being made to give more attention to special aptitudes of these persons and to increase opportunity for training for better jobs.

Surveys conducted by the Department of Labor and the Veterans Administration, the Civil Service Commission, the U. S. Chamber of Commerce, the National Association of Manufacturers and the Accident Prevention Department of the Association of Casualty and Surety Companies are claimed to produce convincing evidence that, when properly placed, the physically handicapped worker can offer a performance as good as or better than the unimpaired worker.

The aid of physicians should be sought, as proper placement in many instances will depend on medical advice. To gain this end, members of the medical profession can offer to advance their services.

Postgraduate Course on General Medicine

On September 21, 22, and 23, the Frank E. Bunts Institute and the Cleveland Clinic will present a continuation course for physicians on "Practical Problems in General Medicine." Dr. M. A. Blankenhorn, professor of medicine at University of Cincinnati, will give the evening address September 21 on "The Rickettsial Diseases." The other out-of-town guest speakers will be Dr. D. W. Pickering, who is director of the Medical Unit, St. Mary's Hospital, London, England, and Dr. E. Braun-Menendez of Buenos Aires, Argentina, who will speak on "Pathogenic Basis of the Treatment of Hypertension."

Inquiries regarding the complete program and registration can be addressed to the Director of Education, Frank E. Bunts Educational Institute, 2020 East Ninety-third Street, Cleveland 6, Ohio.

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FOR SALE: General practice in town of 3,000 with rich farming community and 3-room office in down-town section; drugs and fixtures available; town has small hospital and laboratory; 25 miles from city hospitals; physician recently deceased. Mrs. J. S. Hull, Hicksville, O.

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Symposium for Medical Officers Scheduled Oct. 23-28

To keep military reserve medical officers of the Armed Forces—Army, Navy and Air Force—posted on the latest developments in the field of medical science, a medico-military symposium for officers of the Fourth Naval District will be held at the U. S. Naval Hospital, Philadelphia, Pa., from October 23 to 28.

Presentations and panel discussions are scheduled in aviation medicine, national defense in case of disaster or attack, national preparedness, psychiatry, submarine medicine, surgery, and orthopedics. An outstanding panel of civilian and military physicians are scheduled to take part in the symposium.

All members of the medical profession are invited to attend. Further information may be obtained by writing the District Medical Officer, Naval Medical Reserve Program, Fourth Naval District, U. S. Naval Base, Philadelphia 12, Pa. It is suggested that those who plan to attend make hotel reservations in advance.

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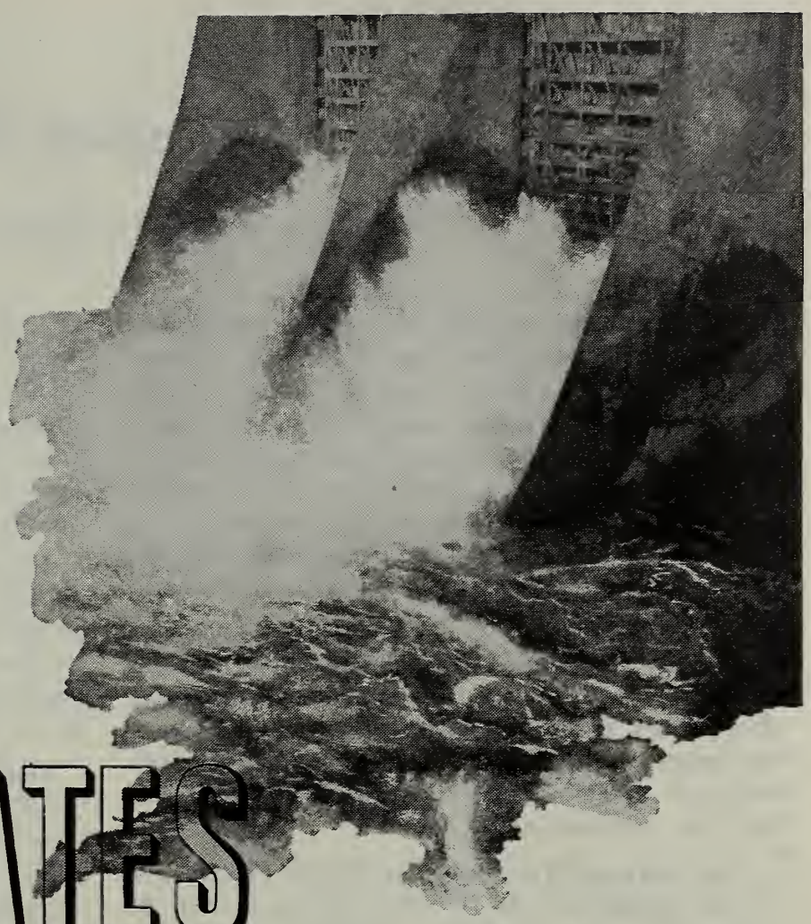
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1. Beckman, H.: Treatment in General Practice. Philadelphia, Saunders, 5th ed., 1946, 704-705.
2. Beckman, H.: Treatment in General Practice Philadelphia, Saunders, 6th ed., 1948, 744.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Medical Ethics, by Charles J. McFadden, O.S.A,. Ph. D., with an introduction by Fulton J. Sheen, Ph. D., D. D. ($3.50. Second Edition. *F. A. Davis Co., Philadelphia),* sets forth in clear terms the ethics and concepts involved in the care of the sick according to the Canons of the Roman Catholic Church. While written previously for nurses, the contents are equally valuable for the medical student, the physician and the hospital administrator.

Surgery for Nurses, by James Kemble, F.R.C.S. ($4.50. *Williams & Wilkins Co., Baltimore, Maryland),* is by an author with much experience in teaching nurses. This book has 374 illustrations of which many are in color. A good text for the surgical nurse.

The Surgical Treatment of Facial Injuries, by V. H. Kazanjian, M. D., D. M. D., and John M. Converse, M. D. ($10.00. *Williams & Wilkins Co., Baltimore, Maryland),* is based upon the experience of these two great facial surgeons covering two great wars and the years between. The text is devoted, however, to their experiences and so actually treats of every kind of facial injury. Profusely illustrated with "before-and-after" portraits, the text puts emphasis on the psychological and sociological aspects of these deformities and the problems of rehabilitation.

Allergy in Relation to Otolaryngology, by French K. Hansel, M. D. ($2.50. *Bruce Publishing Co., Minneapolis, Minn.),* is an official publication of the American College of Allergists. At the annual Congress of the College a panel is offered and this is a transcript of one of these panels and the discussion that ensued. It is brief, concise and to the point.

Functional Localization in Relation to Frontal Lobotomy, by John F. Fulton, M. D., ($3.00. *Oxford University Press, New York City),* is the book of the William Withering Memorial Lectures at The Birmingham Medical School in 1948. Dr. Fulton reports the material derived from the psychobiological technique of Yerkes and the neurosurgical approaches made possible by the pioneering efforts of Sir Victor Horsley in Britain and Harvey Cushing in the United States. The author outlines the fine things these investigators have in store for all of us especially those who without their services would stay hopelessly mentally ill.

Mitchell-Nelson's Textbook of Pediatrics, edited by Waldo E. Nelson, M. D., with the collaboration of 63 contributors ($12.50. Fifth Edition. *W. B. Saunders Co., Philadelphia),* has been well received ever since our own Dr. Mitchell wrote the first edition. It is a text designed to meet not only the undergraduate's need but that of the graduate physician as well. The book has been brought up to date by a careful and complete revision.

Histopathology of the Skin, by Walter F. Lever, M. D. ($10.00. *J. B. Lippincott Co., Philadelphia),* places the emphasis on those diseases of the skin in which the biopsy can be helpful. Rich in illustrations and bibliographic references. It is most welcome.

Digitalis and Other Cardiotonic Drugs, by Eli R. Movitt, M. D. ($5.75. Second Edition. *Oxford University Press, New York City),* is a treatise which gives in one volume what each of us ought to know about the history, the usefulness, and the newer findings of these drugs.

Brucellosis, Clinical and Subclinical, by Harold J. Harris, M. D. ($10.00. Second Edition. *Paul B. Hoeber, Inc., New York City),* has stood out as an example of the research that a physician in a rural area can do if he puts his mind to it. This edition has been made complete in every chapter. Observations on an additional 450 cases have been included. This 600-page book with comprehensive treatment and its 742 references is our best work of reference.

Problems and Emotional Difficulties of Negro Children, by Regina M. Goff, Ph. D. ($2.50. *Bureau of Publications, Teachers College, Columbia University, New York City),* is a study in selected communities and attributed by parents and children to the fact that they are Negro. The study deals with the manifest difficulties as they appear to the children themselves.

You and Your Health, by Aiken Welch ($2.50. *Pellegrini & Cudahy, New York City),* is another guide for women, written in the conservative manner. The book is simple, accurate and not frightening.

Your Rheumatism and Backaches, by Joseph D. Wassersug, M.D. ($2.50. *Wilfred Funk, Inc., New York City),* presents in 300 and some pages the modern knowledge concerning this subject—a very helpful mass of information for the victim.

Hamatin Compounds and Bile Pigments, by R. Lemberg, Ph. D., and J. W. Legge, M. Sc. ($15.00. *Interscience Publishers, New York City),* tells of their constitution, metabolism, and function. The authors, two well-known Australian scien-

tists, have brought us the only monograph in English in this field. Hence, this belongs in the library of every medical society, medical school and hospital in this country. In textbooks of biochemistry and physiology, we do not find this subject treated with the care and completeness that it deserves.

Living Safely, by Earl C. Bowman and Paul F. Boston (80 cents. *The Macmillan Co., Chicago, Illinois)*, strips the problem to the basic issues involved—the proper correlation of Education, Engineering and Enforcement. The attempt in education must carry the development of the necessary.

Facts for Childless Couples, by E. C. Hamblen, M. D. ($2.00. Revised Fourth Printing. *Charles C. Thomas, Publisher, Springfield, Ill.)*, serves us well by making our methods logical, ethical, and scientific. The book has the reception that it richly deserves.

The Psychoanalyst and the Artist, by Daniel E. Schneider ($4.00. *Farrar, Straus & Co., Inc., New York City)*, is a tentative exploration into the nature of true talent and genius and the essential attributes of genius with some attention to the forces that inhibit or encourage its full development. The author also points out the personal dangers and advantages its possession brings.

Slender Legs—A Home Method, by Marguerite Benson ($5.00. *The Author, 135 E. 58th St., New York City)*, is an illustrated text of exercises designed to reshape and strengthen the legs. It insists that ill-shaped legs are not inherited. It is the tendency to neglect this acquired character that is inherited. It advocates manipulation, massage, foot hygiene, and muscular activity.

When the Doctor Says It Is Nerves, by Henry Jerome Simpson ($1.25. *Morehouse-Gorham Company, New York City)*, is planned to meet the need of "nervous people" in search of help from the printed word. It does give a simple, brief, but factual account of how they happen to be nervous, what it means and does not mean, and what they can do to rid themselves of this particular form of torture.

Principles and Practice of Therapeutic Exercise, by Hans Kraus, M. D. ($6.00. *Charles C. Thomas, Publisher, Springfield, Ill.)*, presents fundamental knowledge of exercise therapy and the practical application of such knowledge to specific conditions. Based on his broad experience and his carefully documented observations, the author gives us the real WHY and HOW of such programs of treatment.

The Population Upsurge in the United States, by Joseph S. Davis ($1.00. *Food Research Institute, Stanford University, Stanford, Calif.)*, brings out clearly how little validity there is to predictions as to when the population of this country will begin to decline. The changes that already have occurred require a reorientation of our economic thinking and a completely new consideration of national, state, and local policies.

Public Health Is People, by Ethel L. Ginsburg *(The Commonwealth Fund, New York City)*, is the report of an institute on mental health in public health held at Berkeley, California. Your reviewer along with many others, has insisted that what really matters is the health of the public. Public Health, therefore, consists of what knowledge we have applicable to groups of peoples—to society. Certainly, then in considering the mental aspects of the health of the public, we are dealing with those preventive efforts that have mass application. Nevertheless, those who practice in this field must never forget that they are dealing with people. They must approach the problem as psychiatrists and not as engineers. They should also keep to their own field. The great bulk of these people who need help must get it from the clergyman, their personal physicians, and from such psychiatrists to whom they are sent. There is too great a tendency nowadays to feel that it is a function of government to train some 60,000 specialists in mental disease and maintain this group of experts with funds out of the public treasury. This moves toward socialism and when we are forced to share our poverty it will be necessary to have one psychiatrist for five of us.

Urological Surgery, edited by Austin Ingram Dodson, M. D. ($13.50. Second edition. *C. V. Mosby Co., St. Louis, Mo.)*, has 12 contributors and 645 illustrations. It successfully presents the everyday problems arising in its field.

Postgraduate Gastroenterology, edited by Henry L. Bockus, M. D. ($10.00. *W. B. Saunders Co., Philadelphia)*, presents a course given under the sponsorship of the American College of Physicians on this subject. This should be enough to recommend this text as one means of keeping oneself up to date.

Plenty of People, by Warren S. Thompson (Review edition. *The Ronald Press, New York City)*, discusses the world's population pressures, problems and policies, and how they concern you and me. The author who is director of the Scripps Foundation for Research in Population Problems at Oxford, Ohio, is an outstanding authority. With the enormous rate of population increase in all the world, food supply, health, and wars become of major personal interest for which we as biologists should have a positive solution rather than the usual negative one of hoping to control birth by education or government planning.



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Bronchoscopy in the Newborn

C. C. ROE JACKSON, M. D.

TODAY more and more otolaryngologists are being confronted with the problem of endoscopy in the newborn, especially in institutions where one is associated with a large obstetrical and alert pediatric service. Perhaps the advantages that endoscopy offers are not recognized, or if they are recognized, there may not be on hand, as yet, the proper facilities, instrumentaria and trained personnel to handle the situation successfully. It is hoped that the previous papers,[1, 2, 3] this, and subsequent discussions, may help to outline some points to aid the younger physicians, especially otolaryngologists, to meet with dexterity this occasional need of the newborn. It should be part of every physician's training to be able to recognize and evaluate promptly, the difficulties of the newborn so that the proper procedures may be used at once, not only to save the life, but to preserve it in the best state of oxygenation, for as successful a future individual as possible.

To help evaluate asphyxia neonatorium[4] at least the following data should be available: (a) the age and health of the mother; (b) the number of her babies living and dead and whether full term or not; (c) drugs used for analgesia and anesthesia during labor and delivery; (d) presentation (breech); (e) type of labor (long and difficult); (f) the position of the placenta with or without disturbed circulation; (g) cord position; (h) manner of delivery (version, forceps, etc.). The part that each may play in an individual case must be duly evaluated and the proper after-treatment carried out. For example, when one considers the number of adults who are allergic to drugs, one should not be too surprised to find these small individuals sensitive also. Indeed an allergy could conceivably produce a profound effect on the lumen of an already small bronchus.[9] The ideal analgesia or general anesthetic as yet does not exist, but at present, local or continuous caudal anesthesia[5] would seem to be most nearly ideal.

Since the respiratory tract can contain no air until the infant arrives in the outside world, the first necessity is to clear the tract for the intake of air. It has been shown that respiratory movements occur during intrauterine life, and if this has happened, there may be amniotic fluid, meconium, vernix caseosa and later mucus and blood in the upper respiratory tract,[6] e. g., nose, mouth, pharynx and trachea. In spontaneous cases, nature, with the head already delivered, temporarily pauses, allowing fluid, mucus, etc., in the upper respiratory tract to escape by gravity, and later the compression of the thorax during delivery of the shoulders forces more of it out. This makes way for the entrance of air into the respiratory tract, even before the cord is severed and the fetal circulation changes. However, since all deliveries are not simple and spontaneous, this mucus, etc., must be either aspirated

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very gently or allowed to drain out with the head low, the 15-30° Trendelenburg position being commonly in use.

Most attendants at the arrival of the newborn, have been handed down information on what to do in a general way, for example, holding the infant up by the feet, head down, and slapping the back to stimulate the first cry. This is a good position to allow clearance of the airway, but enhances the possibility of intracranial hemorrhage. The gentler, more scientific, and more accurate ways are supplanting the old crude procedures. The aspiration of foreign material (amniotic fluid, meconium, cellular debris, mucus, blood, etc.)[6] during labor and delivery, occurs more or less in most every case, but only a few have trouble clearing it spontaneously or with minor assistance. The premature baby is more often in need of help.

SPECIFIC PROBLEMS

Farber[6] believes congenital atelectasis can be divided into (A) initial type where (i) mature alveoli have never expanded or (ii) premature type where the lung tissue consists of immature alveoli in varying amounts and (B) the acquired type of atelectasis where the ciliary movement of a mucous plug produces negative pressure and local atelectasis.[10] How much aid can be given such cases, depending on the diagnosis and on what they may need, is the question. Often these problems arise as an emergency, especially in the premature infant, and one does not always have the assistance in diagnosis that X-ray studies give for atelectasis and the cardiac silhouette. There is room for experimental work on the ciliary activity of the trachea and bronchi of the newborn (full term and premature) to determine the efficiency of this system to rid itself of such foreign material, and just what potentiality it has for producing atelectasis behind a plug of mucus.

The larynx may also obstruct the airway because of such things as laryngomalacia (here the epiglottis is not only curled on itself, the sides toward the midline, but the whole thing tending to drop down into the glottis), partial stenosis because of a web or large vocal bands, and recurrent nerve paralysis possibly due to birth trauma, or, rarely, to a congenital defect. A direct laryngoscopy can readily detect the presence and degree of any of these obstructive factors. Inspecting the larynx and finding it to be within relatively normal limits, all factors being considered, the next concern is the trachea and bronchi.

Pressure from without, may cause considerable narrowing of the trachea[7] and interfere with the lumen of the airway. A diffuse compression of the trachea from in front may be an enlarged thymus, but needs corraboration by X-ray studies taken in the anterior and lateral positions in inspiration and expiration. A more or less sharply outlined compression of the trachea or a bronchus would lead one to suspect an anomalous vascular arrangement such as a double aortic arch, or if lower down, an annomalous pulmonary artery.

Partial atresia of a bronchus, usually the right, can be detected easily by bronchoscopy. Should complete atresia be found, then in all probability one is dealing with an aplastic lung, which in itself is not incompatible with life. In the former case, if one were able to confine the end of the bronchoscope to the small opening and with the proper equipment aid expansion[6] of this lung a little, it might be of considerable help, at least for that particular period. To discover a tracheo-esophageal fistula would be of great diagnostic aid.

Finally there may be the lower respiratory tract obstruction, due to thick mucus which shows up later in cases of chronic pulmonary infection associated with fibrocystic pancreatic disease.[8] This type tends to produce the reversed phenomenom of laryngeal obstruction, in that there is epigastric retraction and lower intercostal retraction, without significant episternal retraction. It is indeed of help to know that there is no other associated airway obstruction in cases of this nature, for they in themselves are quite a serious problem. One wonders whether or not some additional artificial expanding assistance such as electrophrenic respiration[12] at intervals, might not aid the natural forces and produce a successful result.

TECHNIC

Some of the small premature infants have a relatively low vitality, which makes the procedure of examining the airway by endoscopy, a more delicate undertaking. Needless to say, one needs all the facilities at hand for any difficulty which may arise. Various isolation features too may be necessary. On most occasions, the infants need to be kept warm and any lengthy procedure should not be used. These infants with low vitality, need extra protection from trauma to the premaxilla which should be well padded with guaze. The less the vitality, the less difficulty one has with the base of the tongue, but one annoying difficulty with endoscopic procedures in the newborn, especially in the more rugged cases, is the tremendous motility of the tongue and its ease of defeating the examination of the larynx, especially by the inexperienced. For this reason, it is more advisable to choose a completely round-bladed infant laryngoscope, or else a type that opens on the side, as is used for inserting intratracheal anesthesia tubes.

Any type of anesthesia is completely contraindicated, because the accurate observation of uncomplicated respiratory movements at all

times, is absolutely necessary. If at any time during laryngoscopy, a laryngeal spasm should occur, astute judgment as to the elapsed time, for the spasm to relax and the institution of treatment such as "mouth-to-mouth" breathing, which is always available, (the operator wearing a mask), or other means of artificial respiration, restores the respiratory movement and exchange.

Having overcome the tongue difficulty, the introitus of the larynx may be difficult to see, because of a poorly developed epiglottis, which tends to drop down and backward, through lack of cartilaginous rigidity to keep it up and the indrawing of air tending to pull it more into the opening. The symmetry of the larynx, arytenoids, cords, etc., are of immediate concern, however, a normal triangular contour of the glottis on inspiration, removes a certain amount of possible hazard. The cords of the larynx are observed in movement—occasionally one will appear to be fixed while the other is normal, but varying positions, tensions and pressure changes with the examining instrument should occur before settling on that diagnosis. If there is lack of movement of one cord, otherwise normal to inspection, it suggests that trauma may have occurred during labor or delivery, or that there may be a congenital defect along the recurrent nerve and its muscle distribution. However, this occurrence appears to be rare.[2]

The introduction of the bronchoscope through the laryngeal opening should be carefully and gently tried. The tissues of the newborn infant traumatize easily and one need not add to the problems of respiration by inducing subsequent laryngeal obstruction. The angled lip on the bronchoscope if turned slightly sideways, slides between the cords more easily than if straight direct pressure is used on the cords.

Once the bronchoscope enters the trachea and the danger of laryngeal spasm is past, the sense of touch of the operator's hands becomes of great value, and, in view of this, the matter of asepsis, I believe, can be overlooked enough to allow the operator to use scrubbed ungloved hands. The grasping of the bronchoscope with the fingers at the open mouth, guides its rate of introduction, and the harmony of finger motion with accurate observation of mucosa moving past the end of the bronchoscope tells the operator all is well. When a certain degree of resistance arises and there is no moving mucosa, this indicates the bronchoscope has reached a point where it fills the lumen, so that to push any further would push the mediastinal structures down, stretch the trachea, and do untold damage. Thus with the utmost care, one recognizes the limit to which one can safely introduce the bronchoscope. The airway should be aspirated and cleaned during introduction. If the lumen is large enough to allow the bronchoscope to reach the carina, it may be easily moved to such an angle that a fairly good view of each bronchus can be obtained. Then, a small suction tip can be gently and carefully passed beyond the end of the bronchoscope into each main bronchus, to aspirate any secretion and further establish a clear airway.

If respiratory distress persists after the bronchoscopy has established the presence of a clear visible airway, one could suspect distal bronchiolar obstruction. Before removing the bronchoscope then, one sees the need of a resuscitator which could be attached to the bronchoscope to give additional aid to the natural respiratory effort. If unilateral peripheral bronchiolar obstruction is present, the end of the bronchoscope might possibly be engaged so that the assistance could be directed to the involved part.

SPECIFIC PROBLEMS WITH CASE REPORTS

Should compression of the trachea exist, due to congenital heart factors,[7] it would be interesting to see what effect an open airway would have on the cyanosis. If, with an open airway, one gets no improvement in the cyanosis, or if it is made worse, the deduction may be made that the difficulty is due to some congenital heart factors.[7] Since so much is being done in heart and vascular surgery, there is greater need for more and more complete information.[7] The bronchoscopist's observations can contribute a great deal to the cardiac surgeon's analysis of the deformity.

CASE REPORTS

Case 1. B. B. This was the first baby of a 22-year-old white woman who went into labor spontaneously at the 36th week of gestation. For three months prior to labor she had lost small amounts of discolored amniotic fluid. Analgesia consisted of demerol® and scopolamine. Anesthesia for delivery was spinal. The duration of labor was 19 hrs. 48 min. and delivery was low forceps with a central episiotomy.

The baby was cyanotic but cried spontaneously. The mouth and pharynx were cleaned by catheter suction. Since the baby was premature and in respiratory distress, he was put in an incubator with continuous oxygen and transferred to the pediatric service. At this time he appeared almost moribund with intense mottled cyanosis of the arms and legs. The respirations were paroxysmal and gasping. There was an intermittent systolic murmur over the precordium. No breath sounds could be heard. The liver was not enlarged. There was no peripheral edema. No gross deformities were noted. Some positive pressure resuscitation was used by the pediatrician.

At the age of 2 hours and 15 minutes, a 3mm bronchoscope was passed easily through the larynx and into the trachea where secretion blocked the lumen of the bronchoscope. This was removed by suction and more grayish fluid was removed from the walls of each main bronchus. The airway appeared clear as far as could be seen and the trachea was cleaned as

the bronchoscope was removed. The breathing seemed easier but there was no improvement in the cyanosis even with oxygen. Positive resuscitation with oxygen was used at intervals, but the baby expired at 6 hours of age.

Autopsy findings revealed complete fibrosis of the left side of the endocardium, almost complete stenosis of mitral and aortic valves, and an aneurysm extending from the left ventricle into the ventricular septum, but not into the right side of the heart. The right side of the heart including the pulmonary circuit was normal. There was no expansion of the lung bases.

* * *

Case 2. R. C. This colored baby had respiratory difficulty starting 24 hours after birth. The respirations had been noisy, labored and rapid. There was suprasternal, epigastric and intercostal retraction on inspiration. The child had a weak cry. At intervals there was a hard dry cough. He seemed to take nourishment fairly well but failed to gain weight in 7 weeks.

On examination he appeared poorly nourished and in respiratory distress even with intercostal retraction on inspiration. He had coarse rales throughout both lungs. He had a left hydrocele and hypospadius. Laboratory findings were essentially normal. X-ray studies of the chest showed an 8mm narrowing of the esophagus and trachea just below the level of the aortic arch, and it was believed to be due to an anomaly of the great vessels. Another film showed a posterior indentation of the trachea at the level of the aortic arch.

Under drop ether anesthesia, a mouth gag was inserted; the pharynx was cleaned with suction and an infant sized laryngoscope introduced. It was impossible to see into the larynx and at the same time allow any air to pass through it due to the curled short epiglottis which produced an antero-posterior entrance to the glottis. A few drops of lipiodol were placed in the arytenoid area and with the head and upper chest elevated it was aspirated into the trachea. X-ray study now showed partial filling of the trachea and there was slight posterior compression of the trachea at the aortic arch level. A tentative diagnosis of double aortic arch was made.

The heart surgeon felt that it would be wiser to wait for a better state of nutrition before exploring the chest. However, after one month of hospitalization and no gain in weight it was decided to explore the mediastinum. At operation a large thymus gland was removed to obtain better exposure. The left carotid artery came from the right and crossed over in front of the trachea. Because the heart stopped beating six times during the procedure, each time requiring cardiac massage, the exact nature of the vascular ring could not be determined. The child's temperature became subnormal and the operation was finished by anchoring the carotid artery to the anterior chest wall. Four hours later the child suddenly expired.

Autopsy demonstrated a vascular ring enclosing and constricting the trachea and esophagus. This was formed in a clockwise fashion by a right aortic arch, the left subclavian artery, a patent ductus arteriosus and the pulmonary artery. In retrospect it was felt that, had the child's condition not been critical, ligation and division of the ductus arteriosus would have released the constriction and allowed the expansion of the trachea and esophagus to the left.

* * *

Cases of atelectasis due to bronchial obstruction present progressive dyspnea with cyanosis, more evident on exertion (crying) but which improves under administration of oxygen. Diminished expansion occurs over the involved area with suppressed breath sounds and there is also evidence of a diaphragmatic tug at the costal margin. Areas of localized emphysema with coarse rales may be detected. With the showing of progressive fatigue and X-ray evidence[11] the diagnosis of this type of atelectasis should be fairly conclusive providing some other difficulty may not be present also.

Case 3. B. S. This full-term baby was the third child of a 27-year-old white woman whose 2 hours 55 minutes labor was induced by rupturing the membranes. A central episiotomy was done and delivery was by low mid forceps. Analgesia was by use of demerol® and scopolamine, and the anesthesia used was nitrous oxide and oxygen.

The baby weighed 3500 Gm. (8 lbs. 2½ oz.) and started to breathe spontaneously. He had a lusty cry. One-half hour after birth his hands and feet became cyanotic and oxygen inhalations were given. At 2 hours of age grunting respirations were noted. At age of 6 hours he had retraction and at 9 hours breath sounds were heard only in the infrascapular areas. Intermittent cyanosis was present. At 13 hours of age there was no improvement and the pediatrician noticed signs of fatigue developing. He had established the diagnosis of congenital atelectasis on (1) progressive dyspnea with cyanosis, (2) diminished expansion, (3) suprasternal retraction, (4) diaphragmatic tug at lower costal margin, (5) suppressed breath sounds, (6) dehydration, (7) progressive fatigue. X-ray studies of the chest were not done at this time but certainly would have lent additional confirmation.

Without anesthesia a 3mm Jesberg bronchoscope was passed through a normal appearing larynx and trachea to the carina. Some mucus was aspirated from the lower trachea. A small suction tip was passed down each main bronchus and a small amount of clear mucus was aspirated. No definite plug was discerned. A clear airway was observed far down into each main bronchus and no anatomical abnormalities were found. The bronchoscope was removed and immediately afterward the breath sounds were heard much better throughout the chest.

The next day there was less retraction on the left side on the chest. An X-ray study of the chest showed mild congenital disseminated atelectasis with emphysema of the peripheral portions of the lungs. On the third day breathing became much easier, but breath sounds were still poorly heard over the right chest anteriorly. On the fourth day the breath sounds were heard well throughout. An X-ray study on the fifth day showed a few remaining areas of atelectasis and decrease in the emphysema. Subsequent progress was normal.

* * *

Aspiration of formula or regurgitated gastric contents may occur, especially in the premature

infant. This not only produces the symptoms and signs of a foreign body in the respiratory tract, but may cause considerable mucosal reaction with subsequent infection in an already sub-par constitution. Bronchoscopy and aspiration, if done promptly and carefully, remove this hazard without injury.

Case 4. G. E. This premature infant (weight 1315 Gm, less than 3 lbs.) was a 31-week gestation and was delivered by low forceps. Breathing started spontaneously but was sluggish. Physical examination was essentially negative, and blood studies normal. The baby was put in an incubator and on routine premature care.

On the 18th day the baby had a period of respiratory distress and cyanosis following a feeding. Aspiration of the pharynx and resuscitation were done. Several hours later there began frequent episodes of cyanosis requiring resuscitation and stimulation. Auscultation of chest revealed numerous inspiratory rales over right chest. With the possibility of aspiration of some formula, it was considered advisable to bronchoscope the patient and remove any foreign material present. A 3mm bronchoscope was passed through the larynx and some whitish mucoid material was aspirated from the trachea. The bronchoscope could not be passed down to the carina, but by moving the head and neck for the correct angle, both main bronchial openings could be seen and no plugs could be detected. A small aspirator was passed down into each bronchus, then the bronchoscope was removed, being sure the trachea was cleaned on the way out.

For about 10 days the baby required careful observation, frequent pharyngeal aspirations and resuscitations because of cyanosis and respiratory irregularity. From then on the baby improved rapidly.

Chest X-ray on 35th day showed findings which probably represented moderately severe disseminated atelectasis of the newborn, although the aspiration factor could not be excluded. X-ray 15 days later showed chest within normal limits.

* * *

With no history of aspiration, and the upper respiratory tract sounding clear, but with cyanosis still present, one is led to suspect that there is not enough lung tissue functioning to give normal balance. Physical signs point to obstruction of a bronchus and X-ray studies show one lung non areated. Bronchoscopy in such a case should lend no risk, remove the possibility of a lumen plug and confirm the diagnosis of bronchial atresia with aplasia of the lung.

Case 5. G. P. This was a full-term baby boy delivered by low mid forceps after a central episiotomy had been done. The birth weight was 2670 Gm. The baby made frequent attempts at respiration and was put in a warm water bath with a respirator over the mouth and nose. Cyanosis was quite marked. Feeble efforts at respiration occurred when removed from respirator. The pharynx was kept clean by aspiration.

Forty minutes after birth a 3.5 mm bronchoscope was passed through the larynx into the trachea to the bifurcation. A small amount of secretion was aspirated from the right bronchus. Only a depression marked the expected left bronchial orifice. The trachea seemed deflected to the right suggesting an atresia of the left bronchus and possibly aplasia of the left lung. Due to the poor condition of the baby, bronchoscopic examination was done with dispatch but this did not alter his condition. Use of the respirator and heat were continued. Death occurred one and one-quarter hours later.

Post-mortem examination revealed a massive left diaphragmatic hernia with hypoplasia of the lungs and marked pulmonary atelectasis. Due to extrinsic pressure the left main bronchus was compressed so that its lumen existed only as a longitudinal slit with the axis in the anteroposterior plane. The abdominal viscera protruded into all of the left and part of the right thoracic cavities.

It was evident that death resulted from anoxia as a result of hypoplasia and atelectasis of the lungs. This in turn was caused by the massive left diaphragmatic hernia, obviously a developmental defect present during most of the infant's life *in utero*.

* * *

If physical signs indicate one lung to be less well ventilated and bronchoscopic examination reveals the bronchus of the involved side to be one-third or one-half the size of the normal side, one may be able successfully to engage the distal end of the bronchoscope over it, and, with some mouth-to-bronchoscope breathing, succeed in attempting to dilate the bronchus and expand the atelectatic lung. This might be enough to help the infant over the difficult period to where the natural forces could carry on successfully. The quantity and pressure of air needed for safe expansion of the newborn's lungs *in vivo* is probably not too well known. Varying degrees of prematurity accordingly would each need special consideration. Yet, we know, some premature babies have survived against tremendous odds, while others, with all available help, and with conditions much more favorable for survival did not.

Case 6. G. H. This baby girl weighing 3125 Gm was delivered by low forceps. Fifteen minutes later there was cyanosis of face, hands and feet with grunting respirations. The mouth and pharynx were suctioned and she was put on oxygen inhalations by mask. She was placed in an incubator one-half hour later. A large amount of mucus was aspirated by catheter with slight improvement in the cyanosis. At age of 2 hours respirations appeared slower, more difficult and grunting was present. She was seen by a pediatrician who noted that the baby was lethargic; chest movements were irregular in rhythm and depth with retraction at the costal margins; breath sounds came through fair anteriorly but were of poor quality over both upper lobes posteriorly; no dulness or rales; she had a systolic heart murmur.

At age of 8 hours, there was no improvement —the cyanosis was present in the extremities and the head and over the left chest to the midline. There was slight intercostal retraction.

A 3mm bronchoscope was passed through a normal larynx into the upper trachea. More

mucus than was expected was aspirated from the trachea. The right main bronchus was of good size and clear. The left main bronchus was about half the size of the right. Both were aspirated. The end of the bronchoscope was engaged over the opening of the left main bronchus and some forced mouth-to-bronchoscope breathing done. Following this the left main bronchus appeared more like the right in size. The color and breathing improved following bronchoscopy.

The next day the baby was much improved with better color. Three days later respirations were normal and there was no cyanosis and from then on the baby progressed normally.

* * *

If the X-ray study should show a pneumothorax following the use of a mechanical resuscitator, then we have, in addition to the airway and pulmonary alveoli not allowing sufficient air exchange, another factor, which prevents expansion and complicates the procedures of treatment. Obviously this necessitates treatment to remove the pneumothorax, and to allow expansion of the lung, followed by the gentle introduction of oxygen to the main airway.

So many times the infant's anoxia is too much a responsibility for the obstetrician and he immediately calls the pediatrician, who, after assessing the problem, grasps for any available help to get more pulmonary ventilation. One of the various types of resuscitators may be on hand, and at present the positive and negative machine seems to be in a phase of popularity. Although the positive and negative pressure this machine produces is less than the physiologists say is safe or necessary to expand the lung of the newborn, they do not synchronize with the respiratory movements of the baby and in fact may be just the reverse so that the positive pressure may be greater than is safe. Assuming that the nose, pharynx, and trachea are clear of mucus, etc., one may be dealing with a laryngomalacia and the positive phase could easily be forced into the stomach, and the negative phase create more negative intrabronchial pressure. Since the desired results do not appear, it seems that an endoscopic examination could eliminate some of these uncertain factors and allow more efficiency in establishing an airway, thus avoiding at least some of the dangers associated with the indiscriminate use of the mechanical resuscitators. Goff[3] states that he believes positive-negative pulmotor type of resuscitators have injured more babies than all other types of treatment combined. At present, my feeling is that with the bronchoscopist's mouth to the end of the bronchoscope the positive and negative phase of added positive and negative ventilation can be synchronized with the diaphragmatic movements by watching the abdomen and done with safety.

The question of whether or not we can safely and successfully use positive and negative pressure in resuscitation of the newborn, especially the premature, needs a great deal of research, which will of necessity combine the efforts of obstetrician, pediatrician, physiologist, endoscopist, pathologist and manufacturer of equipment. It seems that with so much effort being expended in many special branches of medicine, this one too, should be developed, so that many a potentially useful citizen could be given some needed help on his start in the world. A small room adjacent to the obstetrical delivery rooms, for this specific purpose of meeting the respiratory emergencies of the newborn, could be equipped and ready at small expense, in every hospital. This would greatly assist progress in this field.

CONCLUSIONS

1. With the advance of knowledge and improvement in instruments one can safely bronchoscope all full-term newborn infants and many premature babies with safety.

2. More widespread work in bronchoscopy of the newborn should be done so that we may not only dispel its traditional danger but use it freely and advantageously when indicated.

3. By watching the diaphragmatic movements (abdomen) the bronchoscopist with his mouth over the end of the bronchoscope can safely synchronize what added positive and negative ventilation he may feel is indicated with that of the natural effort.

4. Greater cooperation amongst the obstetricians, pediatricians and otolaryngologists is needed as well as greater education, training and experience for those concerned.

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Preliminary Report on "At Birth" Diphtheria, Pertussis and Tetanus Immunization

HERBERT D. CHAMBERLAIN, M. D., and RICHARD E. BULLOCK, M. D.

THE active immunization of young children for diphtheria, whooping cough and tetanus is an accepted procedure; but just when this prophylaxis begins is, in itself, another question.

In a rural general practice such as ours, it has always been a problem to get healthy children into a doctor's office to start immunization at the recommended ages of three or six months. As the usual run of things, we see a child after attending its birth only when it is ill, and that obviously is not the time to begin an immunization program. All this has led, in the past few years, to an unfortunate situation in which the rural child, unless it has an exceptionally intelligent mother, ends up at school age with no inoculations. Various surveys have brought to light the fact that a large population of children have not had their inoculations, with our area being no exception. The implication was that it was the doctor's fault and, therefore, the so-called well baby clinics have been established and lay organizations have taken over a function which we feel properly belongs in the doctor's hands.

PRACTICAL PROCEDURE WORTH CONSIDERATION

Because of the extreme severity of pertussis and its complications in the infant, we searched around for some logical procedure to prevent the very severe illness and even death of the young babies that we have in this community. Any procedure to be satisfactory must fit in with the general routine of the family life. Under present-day methods the parents are apt to forget or, for one reason or another, not to continue a planned series of inoculations.

It occurred to us that an extremely practical way for all concerned would be to give the first shot while we were in attendance at the delivery; the second shot at six weeks at the time of the routine postpartum check; and the third shot at the age of three months when we normally see the children to change their feeding habits. We have made no study in the present literature as to the pros and cons of beginning diphtheria, pertussis, tetanus immunization at various ages. We may be repeating something which has already been done, and may be reporting something which has been previously reported valueless; however, we shall attempt to show in our way that the procedure is definitely worth further consideration.

Submitted February 6, 1950.

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For the past fourteen months we have, at the time of delivery, given 1/2 cc. diphtheria, pertussis, tetanus toxoid to all newborns. We have had no untoward effects from these inoculations; we have seen no abscesses, general systematic reactions nor change in feeding or living habits of the neonatal infant. At six weeks the second 1/2 cc. is given. This is the time when the mothers normally return for their postpartum checks and they have been instructed to bring the babies with them so that they, too, may be checked. This produces no change in a previously established routine. At this age, also, we have seen no untoward effects. Furthermore, this procedure is less costly to the patient since it coincides with the proper postpartum care of the mother. At this time we gently insist that the mothers return when their babies are three months old for the third shot, and in order that we may also check the baby and change its feeding schedule. Our plan, so far, has worked very well.

ENCOURAGING RESULTS NOTED

We are not long on mathematics nor do we have the time or the inclination to prepare elaborate tables. Our results so far are very encouraging. We have, at this writing, inoculated 151 newborns and in none have we seen a reaction. Sixty-eight of these have completed all three of their inoculations and some 20 are in the process of completion. The balance have had at least one, and in most part, two injections. Of the 68 who have completed their injections, we have spot checked 23 with Schick test and with a simple pertussis agglutination test. All of the children tested were Schick negative and all the children tested showed

high titers on the pertussis agglutination reaction. The ages of these 23 children have varied from four to twelve months. We have had no pertussis in any of this group of 151 children that have had at least one injection. We have had at least one baby who has been definitely and directly exposed to pertussis when the disease was in the family in older brothers and sisters, without contracting any of the signs or symptoms of the disease. We have had many mothers tell us of their children's having been exposed to pertussis directly and indirectly, without contracting the disease. We are also extremely impressed with the general health of this group of children. It has been rare indeed to see one of our infants with the so common complaint of running nose, cough and fever that has plagued the general practitioner.

Because of the apathy on the part of numerous parents to have well children seen by the doctor, we send the mothers reminder postcards at the time of the second and third shots, to which we have had perhaps a better response than had we not done so.

CONCLUSIONS

Our conclusions, although not validated by percentages, controls and averages, are that three injections of 1/2 cc. of diphtheria, pertussis and tetanus toxid, one at the time of delivery, one at six weeks and one at three months of age, have protected these children against these three diseases, pertussis in particular; and that, strangely enough, the general upper respiratory infections of the infant child have decreased in this group.

We intend, because of our results, to continue this procedure and feel that it is worthy of further consideration. We hope to report on it again as our series becomes larger.

Failure To Learn from Experience

People fail to learn from experience for three reasons. First, because they have not learned the habit of thought. They bolt their impressions without savouring them, as a dog bolts his food. They do not take their raw material into the factory, but let it pass straight from the delivery gate to the refuse dump. They never classify—that is, they never say to themselves, "Something like this happened before in the same circumstances." Thus they never take the next step, from experience to experiment, to deciding, by repeating the circumstances, whether the likeness observed between two experiences was an accident or a consequence.

Secondly, because they have classified too much, or rather because they have allowed their habits of thought to become automatic. They have organized their factory for mass production, so that it cannot deal with the unusual order. They unconsciously shut out all new experience by classifying everything under headings already fixed. Thus astronomers dismissed for years the observed experience of the variations in the perihelion of Mercury by classifying them under the heading of instrumental error, and correcting for them by averaging observations. Thus scientists in the last war boosted a valueless antiserum for gas gangrene because it had been proved in the laboratory to protect mice from the effects of the intraperitoneal injection of cultures of Clostridium welchii, and supported their advocacy by a series of meaningless observations in the field, while ignoring the significant experience that men transfused early and adequately with whole blood seldom got gas gangrene.

Thirdly, because, having made the whole of one branch of knowledge their province, they fail to attain that last achievement of education, the knowledge of where their experience is inadequate, of where their knowledge ceases and their ignorance begins. Having acquired supreme mastery of one department of learning they are apt to assume that the whole is theirs, to forget that the highest wisdom is the realization that no man can know everything, that he is indeed wisest who knows his ignorance and where to turn for help when he needs it. One of the greatest physicists since Newton died needlessly and before his time because he treated his own strangulated hernia with household remedies and turned only many hours too late to those who had made such ailments their life's study and who could have saved him.

The beginner fails to use experience because to him it is so multitudinous that he cannot handle it until he has acquired some of the technique of the warehouseman or filing clerk. The learned man is often blind to new experience because the mass of knowledge he has acquired seems to him complete, and he sits, old, weary, and disinterested, among his hoards, looking with lack-lustre eyes on any new treasure that is offered to him for acceptance. The ideal is the man of learning and wide classified experience who is yet able to see and appreciate at its proper value the new fact which does not fit into its appropriate niche. Such are our geniuses. Such was Hunter. Such are Einstein and Fleming, —Sir Heneage Ogilvie, British Medical Journal, No. 4629, September, 1949.

Iodine for Histamine

It is suggested that the post iodine hyperacidity which is a result of the stimulation of the parietal cells can be used as a substitute for histamine stimulation. Furthermore, iodine is less harmful than histamine.—G. Papayannopoulos, M. D., in Brit. Med. J., March 4, 1950; pp. 520-521.

Recent Concepts in the Study of Infertility*

HUBERT D. CLAPP, M.D., and DAVID R. WEIR, M.D.

THROUGHOUT the period of recorded history the childless couple has been a major social problem. It is a complex one and its solution extends beyond mere conversation, encouragement and indefinite expectancy. Investigations of the past twenty to thirty years have opened new approaches concerning our knowledge of the factors responsible for both male and female fertility.

For centuries, people have sought cures for sterility. Mystic measures, aphrodisiacs, love potions, and baths were used extensively as therapeutic measures. Evidence of organotherapy appeared in Biblical times. As the result of Paracelsus' teachings, normal organs and juices of man and animal were used to treat sterility from the Sixteenth to the Eighteenth Centuries.

The basis of modern endocrine therapy can be accredited to the work of Berthold in 1849, when he proved the effect of the removal of the testicle on physical and psychologic reactions. Along with advancement of endocrinology much work has been done in the field of mechanical and microscopic procedures to effect the treatment and ascertain the causes for sterility.

At the outset it is well to define the term infertility and its relationship to the term sterility. The terms are sometimes used synonymously. Meaker, however, stated that infertility is an all-inclusive term embracing any degree of conceptive capacity below the level of physiological perfection, and so includes relative fertility, relative sterility and absolute sterility. Relative sterility is that condition in mating in which conception may take place, although unlikely until the existing precluding factors in either mate are overcome. Absolute sterility is that condition in which there is failure of production of gametes in either sex.

From the clinical standpoint, sterility in a mating is the inability to reproduce. Moench states, "If we consider the ideal fertility of an individual as ten, then the combined fertility of two such individuals would be ten times ten, or one hundred per cent. Clinical sterility is present when fertility sinks below sixty per cent. Sixty can be made up roughly of various figures, 9x7, 8x8, etc., and thus one sexual partner can within reasonable limits make up for the infertility of the other." Therefore, it is obvious that the fertility of a couple is to be considered, and not merely that of an individual.

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The majority of the couples with the complaint of "childlessness" present themselves in the person of the wife to a general practitioner or family physician. This doctor must appreciate the complexity of such a problem and should know the basic physiology of fertility to advise these patients properly.

It is futile to start any type of investigation of infertility unless the husband and wife appreciate that the aid of several physicians will undoubtedly be needed before a complete study can be done. The couple should be cooperative and willing to undergo any procedure recommended by their physician. A simple explanation of the physiology of menstruation and conception should be given to the patients as well as a description of the major factors which might be contributing to their infertility. If time is taken to explain these with the aid of models and diagrams the patients apprecate the necessity for an exhaustive investigation and are more willing to undergo the procedures recommended by the physician.

The factual data presented in the following paragraphs have been obtained from the records of 125 consecutive couples studied at the Infertility Clinic of the Maternal Health Association of Cleveland. No couples have been accepted unless they had been infertile for at least eighteen months, not including periods of separation or the use of contraceptives. In all cases complete examinations of both husband and wife have been done and all have been followed for a period of at least six months.

The requisites for normal fertility in the female may be summarized as follows:

1. Normally functioning ovaries, in which there is cyclic maturation of Graafian fol-

licle with ovulation and subsequent corpus luteum formation.

2. A normal uterus, reactive to stimulus of the sex hormones.

3. A patent and receptive genital tract which permits migration of the sperm and ovum and subsequent travel of the fertilized ovum to its site of nidation.

4. Protection and nourishment of the developing embryo.

The requisites for normal fertility in the male are:

1. Production of adequate numbers of normal sperm.

2. Secretion of a fluid medium favorable for conveyance of sperm.

3. A patent ductile tract, permitting transport of the sperm to the vaginal canal.

4. Adequate performance of coitus.

The complex problem of infertility should be routed through several physicians whose distinctive abilities in internal medicine, gynecology and urology will enable them to contribute their special talents to the problem. In many cases the radiologist, psychiatrist and endocrinologist must enter into the investigation.

The Role of the Internist

The function of the internist is to investigate the constitutional factors which may make up a large percentage of the factors contributing to lowered fertility in both sexes. They can be classified as follows:

ENDOCRINE DISORDERS

In our experience true endocrinopathy as evidenced by hormonal imbalance is a rare cause for infertility. In 125 couples we have not encountered a single case where ovarian or testicular dysfunction has been clearly associated with dysfunction of other endocrine glands. In all cases of severe oligospermia, azoospermia, very irregular ovulation or anovulation, the indicated hormone output assays are done. In one anovulatory woman the gonadotropin output was below normal but exhaustive search failed to reveal any other evidence of pituitary failure In two women having very irregular ovulation there was moderate hirsuitismn and a tendency to masculinization but their 17-ketosteroid outputs were normal and there was no other evidence of hyperadrenalism. Not a single man with severe oligospermia or azoospermia has shown an abnormally low or high gonadotropin output or any other clinical evidence of pituitary dysfunction. Testicular biopsies in these patients show varying degrees of arrest of maturation of tubular elements without hyperplasia, and in the great majority of cases there simply is no explanation for the anatomic abnormality.

In approaching the problem of treatment with these facts in mind we have come to be in accord with the general opinion of careful investigators in the field. Gonadotropins have little if any place in the treatment of male or female infertility. It is illogical to think that, if the pituitary is producing normal amounts of gonadotropin, there is any need to provide it in excess. A few of our patients, often on their own insistence, have been treated with various commercial gonadotropins. No benefit was derived in any case. The one anovulatory female with low gonadotropin output was given large amounts of several preparations without the production of ovulation. In such a case we do believe that gonadotropins should be given a thorough trial. We agree with Tyler who stated that the effectiveness of endocrine therapy in sterility is limited by the important facts that the majority of cases of infertility are not of endocrine origin, many of the preparations available are clinically ineffective, and exact diagnoses of some endocrine disturbances are most difficult to establish.

In the investigation of possible thyroid dysfunction we have not had a single case of florid hypothyroidism or hyperthyroidism. The basal metabolism of all patients is determined and on all borderline cases blood cholesterol levels are done. In many patients we have used desiccated thyroid extracts empirically, but are not yet in a position to make a statistical analysis of the results. In women we are not impressed by the results. In men with moderate oligospermia some show increase in counts on the exhibition of thyroid extract. In two of these conception resulted when the counts had exceeded 60 million; and in one, after conception had taken place and thyroid had been discontinued, the count returned to the pretreatment level of 30 million. Perhaps an observation which we, again, cannot yet confirm by statistical analysis may be very important. A number of patients treated continuously for several months or more with thyroid extract have shown a marked fall in their counts, sometimes preceeded by a temporary rise. We are beginning to believe that prolonged thyroid therapy does more harm than good, and that brief treatment with high doses is the method of choice. Again there is no collateral clinical evidence to support the theory that oligospermia is sometimes due to lack of thyroid substance.

Estrogenic substance has a limited usefulness in the treatment of infertility. We have used cyclic estrogen therapy in anovulatory women in an attempt to reestablish ovulation. If ovulation does not occur after four courses of therapy the attempt is abandoned. An oral preparation has been very effective in producing the artificial menstruation and we see no reason to give parenteral preparations. The results have been

very disappointing and in only one case has the cyclic estrogen therapy coincided with the reëstablishment of ovulation.

In the evaluation of any type of endocrine therapy it must always be kept in mind that the therapy preceeding conception may have had nothing to do with the event. Conception often occurs for no reason that can be discovered, even after many years of infertility. Many variables always exist and they must all be taken into account before valid conclusions can be drawn.

DIETARY FACTORS

There is no positive evidence in human beings that deficiency of known vitamins or other constituents of the diet has anything to do with infertility. In animals deficiency of Vitamin E or of vitamins of the B group does impair fertility, and it is not unreasonable to believe that in human beings vitamins or vitamin like substances may play a role in the maintenance of normal fertility. In our clinic the patients submit a detailed dietary history covering a two-weeks period. These histories are analyzed by a dietitian who then instructs the patient in the correction of any deficiencies which may be found. A real attempt is made to provide the patients with foods which contain adequate amounts of all vitamins and vitamin-like substances. We see no reason to give supplementary vitamin preparations unless clinical vitamin deficiency exists. We believe that natural foods provide enough of the known vitamins and also include unknown vitamins which may be necessary and which may not exist in the refined commercial preparations.

OTHER PROBLEMS FOR THE INTERNIST

Every effort must be made to discover and correct any condition such as anemia, infection, obesity, malnutrition, alcoholism, chronic fatigue or disease of any kind. A brief assessment of the psychiatric status of the patients may uncover a need for counselling, psychiatric consultation or psychotherapy.

In many reports of infertility studies great stress is laid on the importance of the so-called constitutional factors. Certainly they should be corrected if possible, but there is no positive evidence that they are of definite importance. We believe it to be not at all unlikely that these constitutional factors occur just as frequently in the population as a whole or in the group with a high fertility index as they do in the subfertile group.

The Role of the Gynecologist

The investigation of the female genital tract should be conducted by the gynecologist. Gross abnormalities quickly will become apparent and may allow the diagnosis of absolute infertility to be established. In the great majority of cases the abnormalities found could ordinarily be considered to be minor in nature if the problem were other than one of infertility. The gynecologist must do a thorough pelvic examination, Huhner's test, Rubin's test, and salpingograms if necessary. By basal body temperature determinations he must determine if ovulation is occurring and its time of occurrence. Vaginal smears or endometrial biopsy may be done to supply confirmatory evidence but are rarely necessary. The patient must be instructed in the timing of intercourse so that it will coincide with ovulation.

CERVICAL FACTORS

Pommerenke has determined the amount and characteristics of the endocervical secretion at various times during the menstrual cycle. At the time of ovulation he found it to be increased in amount with lowered viscosity, diminished cellularity, and increased glycogen content. In this secretion the motility of spermatozoa is preserved for a longer time than it is in secretions obtained at other times in the cycle. The postcoital examination of the endocervical secretions at the time of ovulation, "Huhner's Test," is essential and gives much information. It may reveal the presence of an undiscovered endocervicitis which requires treatment. Not infrequently a negative test may be made positive by the use of a precoital douche containing 10 per cent dextrose in Ringer's solution. The usual cervical abnormality is a simple cervicitis which yields readily to treatment. We have not had any cases of stenosis of the cervix and believe that dilatation is rarely if ever indicated.

UTERINE FACTORS

A considerable number of infertile women have a small uterus. We do not have information to show whether this occurs any more frequently in infertile women than in nulliparous fertile women. Usually attempts are made to correct the abnormality particularly if anteflexion is present. Estrogen therapy may be of some value in increasing the size of a small uterus or in preparing it for nidation of the ovum. Douglas reported evidence of enlargement of the small uterus with the use of a stem pessary for a period of one to three months. In our series we have not encountered a single infantile uterus.

Retroversion of the uterus is another problem which is frequently encountered. It should be corrected although there is no good evidence that it contributes to infertility.

Obvious ovarian pathology must be corrected by surgical measures if necessary. A not uncommon cause of anovulation is the development of multiple small cysts in the ovaries. Apparently the basic defect is the failure of the follicles to rupture. The ovaries may be palpably enlarged. Partial removal of the cap-

sules or wedge resection of the organs may reëstablish normal ovulation. The use of the culdoscope facilitates the establishment of the diagnosis and the diagnosis of endometriosis and other pelvic conditions without the necessity of performing laparotomy. (Our experience with this instrument is still very limited.)

TUBAL FACTORS

Great emphasis is always laid on the factor of tubal patency. In our experience tubal occlusion is an uncommon finding. In our series of 125 couples bilateral tubal occlusion has been found only six times. Unilateral occlusion has almost invariably been due to surgical removal of the tube. A negative Rubin's test does not mean tubal occlusion. Routinely if the Rubin's is negative we repeat it twice, using sedatives as indicated. Then salpingograms are done. As regards surgery to correct tubal occlusion we are in agreement with the majority of careful workers in the field. It is rarely indicated. It is a major surgical procedure, the results even in the best of hands are poor, and there is real danger of preparing the ground for a tubal pregnancy. Too often it is forgotten that any degree of tubal occlusion may well mean that the functional integrity of the entire tube is damaged. A decision to perform surgery should be made only by a gynecologist who has had wide experience with the problem.

OVARIAN FACTORS

In 1904 Van de Velde first reported variations in the temperature of women during the menstrual cycle, and in 1929 he confirmed his findings with additional data. In 1938 and 1939 Zuck published the results of basal body temperature studies in 278 cases. He demonstrated that fertility was highest on the twelfth, thirteenth, and fourteenth days of the normal 28-day cycle, coinciding with the observed temperature shift. In recent years the daily charting of basal body temperatures has been accepted as the most reliable, easily available means of determining if ovulation occurs and when it occurs.

The greatest disadvantage of this method is evident when the attempt is made to predict the ovulation time of a woman who does not ovulate and menstruate regularly. For the vast majority of women the interval between ovulation and the onset of the next menstrual period remains standard and varies in different individuals from 13 to 16 days. If a woman's menses occur irregularly the variation in number of days will all be taken up in the period between the onset of menses and the occurrence of the next ovulation, the period between that ovulation and the next menstruation remaining standard. With irregular menses, therefore, the physician is unable to predict when ovulation will occur at the time when it is important that he do so, namely, in the postmenstrual, preovulatory period. With regular menstruation this period also remains standard so that ovulation may be predicted accurately. Recent work by Farris using immature female rats as test animals may solve the problem of predicting the time of ovulation in women who menstruate irregularly.

Routinely our patients record their basal body temperatures for three to four months, or until the time of the temperature shift is accurately established. They abstain from intercourse for at least four days before the temperature shift and then have intercourse on alternate days. If conception does not occur, the initial intercourse after abstinence may be one or two days before or after the beginning of the temperature shift. Farris' work indicates that ovulation actually may occur just before, during, or just after the temperature shift. The above schedule takes into account this probable fact and also the survival time of ova and spermatozoa. There is evidence to show that neither of these probably survive as viable gametes for longer than twenty-four to forty-eight hours.

The Role of the Urologist

A thorough examination of the external and internal genitalia is necessary to discover evidence of testicular atrophy, epididymitis, prostatitis, or abnormalities of the duct system. Semen analyses must be done and in a few cases testicular biopsies are indicated.

SEMEN ANALYSIS

The semen must be collected in a clean glass jar either by withdrawal at the end of the intercourse or by masturbation. It should be kept at approximately room temperature and delivered promptly to the doctor's office. The analysis should include volume determination, an accurate count, observation of the motility of the sperm and a differential count of the stained smear to show the number of abnormal forms. The most important part of the analysis is the count per cubic centimeter and this should exceed 60,000,000. The total count is less significant. There is considerable controversy at present about what values actually are normal for semen, but space does not permit a discussion of the various factors. Usually normal or abnormal motility or morphology closely parallel the count per cubic centimeter. A number of cases are on record where conception has taken place with counts well below 60,000,000. We have had one with a count of 30,000,000.

Often it is most important to repeat the semen analysis. A high count is good, although not necessarily conclusive evidence of the man's fertility, but a single low count may be of no significance. An error may have been made in the technique of collection and the second count

may be perfectly normal. Sometimes too frequent intercourse may deplete the specimen.

TESTICULAR FACTORS

If the testicles are small and flabby with deficient semen we consider the prognosis to be hopeless. However, in the majority of our cases of oligospermia there is no gross evidence of testicular atrophy. Biopsy usually reveals a maturation defect in the germinal epithelium. Adult sperm are produced in very small numbers. Sometimes there is thickening of the basement membranes of the tubules. Why there is a failure of maturation remains entirely unexplained, and at present there is no form of therapy which consistently will correct it.

In a small percentage of cases of azoospermia the testicles are grossly and microscopically normal. In such cases a blockage of the duct system must be suspected with the hope that it may be corrected and fertility restored by an operation such as vasoepididymal anastamosis.

OTHER FACTORS

Chronic, non-specific prostatitis and seminal vesiculitis are frequently encountered. In a few of our cases appropriate treatment has been accompanied by a rise in semen count with resulting conception. However, in many, the counts failed to improve and it is well known that chronic prostatitis may exist in highly fertile men. The whole problem of infertility in the male is very poorly understood. Multiple unknown factors must exist and at the present time we must admit that these are far more important than the factors that are known.

CLINICAL RESULTS

The following table gives the results of the study and treatment of the 125 couples who have been under observation for at least six months. All of them had been infertile for at least eighteen months before they were accepted in the clinic.

		Per Cent
Total cases	125	
Pregnancies	27	21.6
Discharged not pregnant	42	
Absolute sterility—male	15	12.0
Absolute sterility—female	9	7.2
Incomplete study	12	9.6
Complete study, no absolute factor found	6	4.8
Active cases, not pregnant	56	44.8

The group classified as incompletely studied were patients that had had complete initial studies, but did not return for follow-up for six months, and did not show a factor of absolute sterility or achieve a pregnancy. If this group is excluded from the total number of cases the percentage of pregnancies rises to 23.9.

In the male the diagnosis of absolute sterility was made on the basis of persistent azoospermia or severe oligospermia with counts uniformly below 20,000,000 and testicular biopsy material showing irreversible changes. In the female it was made on the basis of anovulation or complete occlusion of both tubes. It is interesting to note that absolute sterility in the male is almost twice as common as it is in the female. It is also much easier to establish the diagnosis in the male. Therefore, if an incomplete study of an infertility problem is contemplated, it is logical that the man should be the first one to present himself for study. The examination of the male is much simpler, more conclusive, and more apt to reveal decisive information. Thus the women may be spared a prolonged, uncomfortable, and expensive investigation. In the woman grossly irregular menstruation or a history of known pelvic disease may lead one to suspect that she is absolutely infertile; whereas in the man there is rarely any clinical evidence to indicate the existence of severe oligospermia or azoospermia. These conditions are usually unsuspected even by the urologist, until he has done a semen analysis.

SUMMARY

We have reviewed briefly, the history of infertility, and discussed the current concepts of this problem. In this discussion we have incorporated our experience as we have seen it in our own clinic, and have explained in considerable detail how each problem has been attacked and presented some of the results of our investigations. We hope that we have contributed something from our experience which will be of value to those interested in this complex problem which is still a challenge and wide open for research.

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Case Report: Eclampsia in a Fourteen-Year Old Negress with 252 Recorded Convulsions

EDUARD EICHNER, M. D., and LLOYD P. MALLIN, M. D.

ECLAMPSIA is a convulsive disorder occurring primarily in young primigravidae. There are many reports in the American literature of eclampsia in women whose ages range "from fifteen to ...," but only three in which patients aged under 15 are mentioned. Rucker, in a discussion of an article by Ware and Noblin[5] reports eclampsia in a twelve-year-old. A survey by Arnell[2] mentions patients aged from 13 to 41, while Adair[1] quotes Hinselmann, whose series starts at 14. Peckham[4] in his modification of Eden's classification states that "more than twenty convulsions" is of grave prognostic significance. The case reported here is of interest because of the patient's age, the extent and duration of her coma, as well as the severity and number of her post-partum convulsions. Other authors agree that in general prognosis is better in the younger age groups, despite the presence of other grave criteria.

The Authors

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CASE REPORT

M. G. C., R-7001, was admitted to Mt. Sinai Hospital in a convulsive state at 7:30 p. m., December 28, 1938. She had had three convulsions before admission, and had been unconscious since the first one. She had had no prenatal care, and had denied her pregnancy to her parents. She had never had any convulsive disorder before the afternoon of admission. Morphine sulfate, one-quarter grain, was given immediately, and the convulsion was controlled by drop ether. A Pezzar catheter was inserted into the bladder, and a modified Stroganoff routine was begun. Therapy consisted of morphine sulfate and 50 per cent magnesium sulfate intramuscularly, chloral hydrate rectally and 50 per cent glucose in distilled water intravenously.

Physical examination revealed an unconscious, gravid negress, fourteen years old, with slight infra-ocular and peripheral edema. Examination of the ocular fundi was normal. The uterus was enlarged to the size of an eight month pregnancy, with a single fetus in vertex presentation. Fetal heart tones were audible, and the presenting part was engaged. Blood pressure was 168/110, temperature 101°F, pulse 128 and respirations 18. Urinalysis revealed 4 plus albuminuria, but no casts or cellular elements were present. Specific gravity was not reported. Emergency blood chemistries were reported as follows:

Nonprotein Nitrogen	25	mgm per cent
Blood Urea Nitrogen	11.3	mgm per cent
Uric Acid	4.6	mgm per cent
Creatinin	1.5	mgm per cent
Glucose	106.0	mgm per cent
CO_2 Combining Power	57	vol. per cent
Total Protein	4.75	Gms. per cent
Albumin	2.85	Gms. per cent
Globulin	1.9	Gms. per cent

From the Division of Obstetrics and Gynecology, Mt. Sinai Hospital, Cleveland.

Admission spinal fluid pressure was 28.0 cm. water. The Pandy reaction was negative, and the cell count was zero. Spinal fluid protein was 36 mgm per cent, the gum mastic curve was flat, and the Kline test was negative on blood and spinal fluid.

Spontaneous labor started four hours after admission, and ended under ether analgesia with the delivery of a healthy, four pound premature infant at 6:02 a. m. on December 29, 1938. The placenta was easily expressed, and bleeding was minimal. No oxytocics were used. Blood pressure after delivery was 140/110. There were no convulsions during labor and delivery. Despite continuation of the modified Stroganoff regime, the first post-partum convulsion occurred 10 hours after delivery. Within the next two hours thirteen additional convulsions were recorded. These were not influenced by medication or drop ether. In addition to a 300 cc. phlebotomy and the removal of 50 cc. of spinal fluid, the patient received 25 cc. of 50 per cent sucrose, 4 cc. of 50 per cent magnesium sulfate and one-half grain of morphine intravenously during this period. By midnight of the day of delivery, there had been 25 convulsions. Blood pressure had dropped to shock level (70/50), and anuria had developed. The patient finally responded to cardiac and respiratory stimulants, and to intravenous fluids.

Convulsions continued despite all therapy, and the patient remained in coma. By the morning of December 31, the second post-partum day, 213 major convulsions and innumerable attacks of localized or unilateral twitchings (not always in the same extremity) had been recorded. A neurologist in consultation advised a revision of therapy: paraldehyde was to replace chloral, lumbar punctures were to be limited to one or two daily, and all other than supportive therapy

was to be discontinued. Before this change was made, 239 convulsions had been charted. Only nine occurred within the next twenty-four hours, and none thereafter. Blood pressure finally stabilized at 110/70. At 2:00 p. m. of the third post-partum day the patient could be roused for the first time, but she did not respond to questioning. She was still stuporous and unresponsive on the fifth day, but had had no convulsion for over 36 hours. Frequent muscular twitching was still present. All sedation was discontinued on January 4, the sixth postpartum day. Blood chemistry and spinal fluid studies remained normal. Albuminuria gradually decreased.

As the effects of sedation wore off, she began to answer simple questions, but it was evident that she could not identify objects by touch or sight. She was considered to have a receptive type (cortical-sensory) aphasia. At no time did the ocular fundi show any pathological changes. Neurological examination on her twenty-first post-partum day revealed an apathetic but well-oriented patient who responded to questions. Ocular movements were normal, and there was no nystagmus. Pupils reacted well to light and accommodation. Vision was only slightly better than light perception. Progress was continuous from this time, and she was discharged from the hospital on January 31, 1939, the thirty-third postpartum day. She was able to get about without assistance, and her aphasic disturbance had disappeared. Perimetric field studies were considered normal. Blood chemistry was reported as normal. There was no albuminuria, although an occasional hyaline, granular or cellular cast was seen. Blood pressure on the day of discharge was 110/80.

During the next nine months her progress was followed in the outpatient department. Vision was 20/50 in each eye, unimproved by glasses. There was a slight bilateral temporal constriction in the visual fields, worse in the left eye. A weak Achilles tendon reflex, as well as a questionable plantar response, was present in the left leg. On November 24, 1939, about eleven months after delivery, the patient reported that she was in her regular grade (9A) at school, doing normal work. She complained only of defective vision.

In the seventh month of her second pregnancy, she was admitted to the Mary B. Talbert Salvation Army Home, and was delivered there on January 8, 1941. Blood pressure and urine remained normal throughout this pregnancy. Reexamination at our dispensary in November, 1941, revealed no change from the previous findings. The third pregnancy ended uneventfully at the Mary B. Talbert Home on June 13, 1942. Restudy of this patient during and after this pregnancy showed only that vision had improved, and could be corrected to 20/25.

Late in her third pregnancy she complained of fainting and dizzy spells suggestive of petit mal. Hadley[3] mentions permanent brain damage as an infrequent sequela of eclampsia. Following neurologic, psychiatric and gynecologic consultation, she was again admitted to Mt. Sinai Hospital (V-8696) on November 16, 1942, where supracervical hysterectomy and right salpingo-oophorectomy were done. All laboratory tests during this admission were reported as normal. She was last seen on December 18, 1942, in the outpatient department. Follow-up was discontinued during the war, and has been unsuccessful since then. We have learned from her father that she is now married, and apparently in good health.

SUMMARY

A case of eclampsia in a fourteen-year old negress with 252 recorded convulsions (4 antepartum) is reported. Brain damage was evidenced by the presence of aphasia, and the delayed development of attacks suggestive of petit mal. Immediate recovery was almost complete and she had two additional uncomplicated pregnancies and deliveries within the next three years.

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Effect of Anticonvulsant Drugs on Retinal Metabolism

3-5-5 trimethyloxazolidine, 2-4 dione (Tridione, Abbott) and 5 ethyl, 3-5 dimethyloxazolidine, 2-4 dione (Paradione, Abbott) are anticonvulsant drugs used in the treatment of epilepsy, particularly petitit mal. Both drugs have similar ocular side-effects. In a clinical study with Tridione, Sloan and Gilger described temporary impairment of acuity, brightness sensitivity, color discrimination, and sensitivity to flicker at illuminations of a high brightness. These workers concluded that the site of action of the drug was at the retinal level. Since it would be expected that drugs producing clinical defects would cause inhibitions of retinal metabolism, this study was undertaken.

Utilizing isolated beef retinae, over-all retinal respiration was inhibited 50 per cent by 0.05 M. Paradione and by 0.10 M. Tridione. At these concentrations glycolysis was not measurably affected. Dehydrogenase reduction of methylene blue was not affected by the drugs; addition of cytochrome did not reverse the drug inhibition of oxidation; and the drugs showed no inhibition of cytochrome oxidase activity. Thus at least part of the inhibition of oxidation seems to be exerted on the flavoprotein link in the oxygen transport chain. Further investigation of this aspect is in progress.

In a preliminary study retinae of white rats, after a month of daily sublethal drug injections, showed an over-all inhibition of respiration by approximately 50 per cent.—A. P. Gilger, M. D., A M.. Potts, Ph. D., M. D., Lorand V. Johnson, M. D., Cleveland, Ohio.

Unusual Ovarian Cyst Developing Post Partum: Case Report

MARION E. BLACK, M. D.

MRS. D. H., age 26, para 0, gravida 1, presented herself at five months of pregnancy. The last menstrual period was November 13, 1947; estimated date of delivery August 20, 1948. The patient had no complaints.

Past History: There were no previous operations and no serious illnesses.

Family History: There is no history of familial diabetes or tuberculosis. The patient's mother and father both have hypertension. One sister had toxemia of pregnancy with her first pregnancy.

Physical Examination: The patient was a well-developed and well-nourished white female weighing 103 pounds. Blood pressure was 110/70. The thyroid was palpable; the chest was clear to auscultation; the heart sounds were normal and heart size was within normal limits. The thoracic and lumbar spine straight. The kidneys, liver, and spleen were not palpable. Fundus was two fingers above the umbilicus. Pelvic measurements and internal measurements revealed an adequate pelvis. There was no pelvic pathology palpable; the cervix appeared normal.

Laboratory Findings: Hemoglobin was 90 per cent; red blood count was 4.3 million; the urine was negative and blood Wassermann was negative. The blood was found to be group AB and Rh positive. X-ray of the chest was negative.

The patient's pre-natal course proceeded uneventfully; blood pressure varied within a normal range; the total weight gain was 20 pounds.

Labor. August 12, 1948. Patient had a two-hour easy labor. Medication used was Demerol® and Scopolamine® and a light Gas-Oxygen-Ether anesthesia. The fetal head was on the perineum; delivery was effected by low forceps and a right medio-lateral episiotomy. The placenta separated spontaneously. Gross examination revealed no abnormalities of placenta or membranes. There was no excessive uterine bleeding.

Hospital Course. The patient's hospital postpartal course was uneventful. No morbidity; no excessive lochia. Patient successfully breast feeding her baby. The newborn baby, a girl, menstruated on the third and fourth days of life.

Six-Weeks Follow-Up Examination. September 25, 1948. Patient still breast feeding her baby. There had been no menstrual period; no excessive vaginal discharge.

Pelvic examination revealed a firm perineum; cervix posterior; uterus anterior, normal in size, freely movable; both ovaries were palpable and normal in size; no adnexal pathology palpable. Small eversion of the cervix on inspection.

Reëxamination. October 12, 1948. Patient complaining of abdominal distention and fatigue. Slight vaginal discharge; No menstrual period; patient still breast feeding her baby.

Abdominal examination revealed a soft mass filling the abdomen and extending slightly above the umbilicus. On pelvic examination the cervix was soft; uterus normal in size and position. By sterile probe the uterus was measured at 7 cm. Left ovary palpable; cyst palpable as noted in abdominal examination; the cul-de-sac was empty.

Six days later, October 18, 1948. Patient complained of shortness of breath. Abdomen tense and the cystic mass extended up to the xiphoid process. Pelvic findings same as on last examination. Patient was admitted to the hospital gynecology service with a diagnosis of serous cystadenoma of the right ovary.

Operation. October 27, 1948. Under sodium pentothal and Gas-Oxygen-Ether anesthetic, right salpingo-oöphorectomy was performed. Through a low midline incision the abdomen was opened. The cyst, filling the entire abdomen to the xiphoid process was tense and grayish-white in color. It was first emptied by suction, approximately two gallons of serous, straw-colored fluid being removed. The collapsed cyst was then removed, along with the right tube, by ligation and sharp dissection.

Pathological Report. "Multilocular cyst of ovary, probably theca lutein cyst." Urine obtained on the fourth postoperative day gave a positive Friedman test. Patient was discharged on her eighth postoperative day in good condition.

Postoperative Examination. November 23, 1948. Patient had no complaints. On pelvic examination the cervix was posterior, and there was a small eversion. Uterus anterior, normal in size; left ovary palpable, normal in size. Pregnancy test was negative.

December 18, 1948. Pregnancy test still negative. Pelvic examination the same.

February 14, 1949. Repeat Friedman test negative. Patient had a normal menstrual period on February 3, 1949.

May 31, 1949. Menstrual periods have been regular for the last four months. No complaints. Pelvic examination the same.

December 1949. Periods have remained reg-

Submitted December 27, 1949.

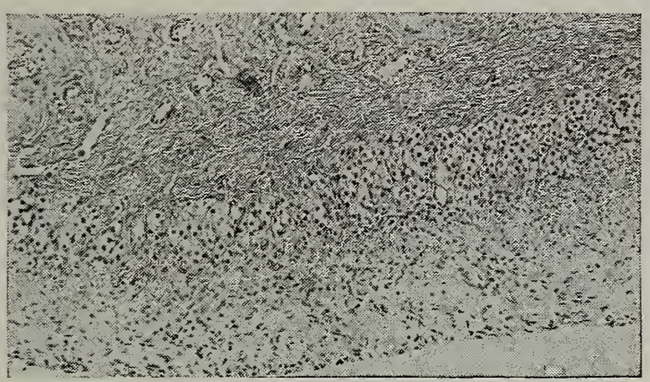
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ular; no vaginal discharge; no complaints. Pelvic examination same as on last visit.

DISCUSSION

This is a case report of a rapidly growing ovarian cyst in a recent postpartum phase of a young primiparous woman. Because of its rapid



Multilocular cyst of ovary, probably theca lutein cyst

growth and easily demonstrable fluid wave, preoperative diagnosis was serous cystadenoma.

The finding of lutein cyst, with a positive Friedman test on the fourth postoperative day (the 84th postpartal day) is difficult to explain. This is certainly too late to occur from a hydatid degeneration of the placenta. Since the placenta was not saved reëxamination of it could not be made.

There is the possibility of a retained hydatid degeneration in the uterus. However, the patient had a normal sized uterus by palpation and by measurement. Patient did not have a bloody discharge and had not passed the usual hydropic chorionic villi. A curettage was not done as such a diagnosis was not suspected and was not done postoperatively as the pelvic findings did not warrant it.

CONCLUSION

In conclusion, this case is presented as a theca lutein cyst, its origin not to be explained by the usual clinical symptoms or findings.

Hyaluronidase: An Aid to Local Anesthesia in Ophthalmology

Hyaluronidase, when added to procaine permits the same to spread much more rapidly through the tissues. It affords a definite advantage in block anesthesia, as well as in infiltration anesthesia. Intraocular operations are accomplished with smaller amounts of novocaine® and the onset of the anesthesia is more rapid and more profound.

—Harvey E. Thorpe, M. D.,
A. Steinberg, M. D., and
L. Greenfield, M. D.,
Pittsburgh, Pa.

Brief authors' abstract of paper presented at charter session of the Association for Research in Ophthalmology, East-Central Section, held in Cleveland, Jan. 10, 1950.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Artery—The ancient Greeks believed that all arteries carried air because they never found blood in the arteries of cadavers. They felt that the "pneuma" or vital air kept the blood out of the arteries and that whenever an artery was cut in a living person the vital air or "pneuma" escaped and was replaced by blood. The term artery comes from the Greek word "arteria," literally a windpipe. The Greek word for air being "aer."

Hermaphrodite—A term of mythological origin. Hermes, the messenger of the Greek Gods, as the male counterpart in combination with the Goddess Aphrodite, presents us with that anatomical anomaly, the hermaphrodite.

Cholera—Celsus in his book De Medicina written about 30 A. D., explained that this disease owes its name to the vari-colored or bile-like appearance of the watery discharges from the bowels. The term cholera is derived from the Greek word "chole" or bile.

Sciatica—A word which has been reduced by time from the Latin term "ischiadicus." This in turn coming from the Greek "ischias," a pain in the hips and from "ischion," the hip joint.

Aspirin—This commonly used drug had its name coined from its chemical composition. The "a" portion coming from acetyl and the remainder of the name coming from "spiraeic acid," which was the old terminology for salicylic acid.

Rickets—A term of uncertain and controversial origin. Various authorities stating that it is derived from: (1) The Latin term "rachis," the spine; (2) the old English word "wrickken" to twist; or (3) the Anglo-Saxon word "hrycy" meaning back or ridge. Daniel Whistler in 1645 used the term rickets stating that the name was said to have been taken from the surname of a quack who was among the first to treat the condition. Another and somewhat fanciful explanation is that it arose in Dorset County, England, where those who were short of breath were said in the native dialect "to rucket." Francis Glisson in 1650 gave a classic description of the condition and used the more technical and Latinized term of "rhachitis or rachitis."

Herpes—A term used from the time of Hippocrates to the present. It is descriptive of the course and type of the skin lesion and comes from the Greek word "herpo," meaning "I creep along."

Koplik's Spots—Henry Koplik of New York City in 1896 first described the initial lesions of measles on the mucous membranes which now bear his name.

—Harry Wain, M. D., Mansfield, Ohio.

The Advantages of Ocular Implants in Enucleation Surgery

DAVID E. ROLF, M. D.

DURING the past three years, the popularity of the integrated implant has advanced markedly as the experiences of surgeons have proved quite favorable with regard to the use of these implants in enucleations, evisceration, and secondary operations. This procedure is approximately four years old, and from a surgical standpoint, it has not been used long enough to really evaluate it conclusively. Nevertheless, it has demonstrated many advantages and such a high percentage of good results as to warrant its continued use and study.

The great advantages of an integrated implant in enucleation surgery lie in the improved cosmetic appearance of the patient; the psychological "lift" which the patient enjoys as a result; the increased motility and the more natural type and scope of ocular excursions; and the absence or diminution of lid lag and eversion of the lower lid. Furthermore, the popularity of plastic protheses together with improvements in the technique of their construction has added to the favorable cosmetic results which are now obtained with this type of surgery.

The operation itself, when properly performed, requires little more time than a standard enucleation procedure and when its advantages are considered, the slight increase in operating time is certainly worth the effort.

DESCRIPTION

An integrated implant is usually composed of methyl methacrylate and tantalum or vitallium, in the form of a globe somewhat simulating the human eye. It is placed in the socket and the conjunctiva is attached around it. However, it is not completely covered because it is connected to the prothesis by means of a small, central peg, which is usually made of gold, tantalum, or plastic. This imparts a degree of motility to the prothesis which can never be obtained with the old type of buried implant where much of the motility is lost because it cannot be transmitted properly to the prothesis which rests on the closed conjunctiva. The excursions of integrated implants are enhanced markedly by the direct attachment of the extraocular muscles to them. These implants, in turn, move the protheses.

Ocular motility is much greater with these types of implants for several reasons. To begin with, none of the conjunctiva is lost, so to speak, and enough space is left during the closure to preserve an area on the surface which would correspond to the area of normal cornea. Secondly, the prothesis can be made smaller because it does not rest on the conjunctiva of the lids, but rests instead on the peg in much the same way that a wheel will rest on an axle. In this way, a much smaller prothesis can be used, and this, of course, diminishes both its weight and size. The cosmetic appearance of the patient is thus improved, and there is a great increase in ocular motility.

When integrated implant operations were first attempted, many questions were raised regarding the possibility of infection as the result of the retention of an implant within a socket which had not been completely closed. However, hundreds of these implants have been used during the last few years, and yet there have been very few reports of infection. As a matter of fact, the entire socket seems to be covered with a mucoid type of membrane that seems to resemble epithelium somewhat and this change in Tenon's capsule seems to account for the absence of infection in practically all cases. Another problem which presented itself was that of allergy. It is also true that perhaps there are patients who are allergic to methyl methacrylate or even tantalum for that matter. However, clinical reports of this have been few and far between. The methyl methacrylate is now heat treated and furthermore, tantalum seems to act as a barrier in some way so that there are practically no definite instances of allergic reactions as a result of the inclusion of an integrated implant following enucleation.

The chief problem with this type of procedure, however, has been the possibility of extrusion, and various implants have been devised to prevent this complication.

The first implants were those devised by Ruedemann and Cutler, and later implants were produced by Hughes, Guyton, Stone, Jardin, Rolf, and others. All these men have attempted variations in design of one type or another in

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an effort to minimize the percentage of extrusions. In the implant which I devised, the neck was made somewhat smaller so that the tissues could be gathered around it in a firm type of closure. Muscles, Tenon's capsule, and epithelium were closed in such a manner that the body of the implant had a much wider diameter than the narrow neck at the surface. It was thought that this would act as a mechanical barrier to extrusion and retain the implant somewhat more firmly.

I am at present preparing a new implant of improved design which I hope will simplify the operation, increase ocular motility, and prevent extrusions.

In general, the implants which have been devised to date fall into four main types:

1. The implant and the prothesis are constructed as a unit. It is inserted in the socket and the muscles are attached to it by means of sutures which are sewed to tantalum mesh. This type of implant has certain disadvantages.

   a. It is difficult to align the muscles properly so that there will be no postoperative strabismus.

   b. It is hard to match the eye at the time of operation.

   c. If the prothesis chips or becomes discolored, one has to literally re-operate the patient.

2. The second type of implant consists of a globe of methyl methacrylate with a ring around its center and a double layer of tantalum mesh on the surface. The muscles are reflected around the ring and each tendon is sewed to the belly of the muscle. Tenon's capsule and conjunctiva are attached to the tantalum mesh.

3. The third type of implant does not have a ring, but instead the muscles, Tenon's capsule, and conjunctiva are attached to the implant by means of sutures imbedded in a double layer of tantalum mesh.

4. A magnetic implant which holds the prothesis by means of magnetic attraction.

Constant improvements are being sought with the following objectives in mind:

   a. Reduction in length of operating time.

   b. An improvement in the cosmetic appearance of the patient.

   c. The prevention of extrusion.

   d. Increased motility.

   e. Prevention of retraction of the conjunctiva and Tenon's capsule from the tantalum mesh which surrounds most of these implants.

In view of the fact that there have been few extrusions, that the operation is not too difficult, and the cosmetic result is so definitely superior, I think it advisable to insert an integrated implant in almost every instance.

KEEPING UP WITH MEDICINE

• An impaired appetite is a satisfactory early guide to digitalis poisoning.

* * *

• Man's perversions from the biologic norm make him pay with discomfort, invalidism, and death.

* * *

• Absolute rest is the main cause of pulmonary embolism and as many patients die from this cause in The New York Hospital as from cancer of the stomach. Maybe we ought to start a society aimed against rest in bed?

* * *

• As a means of securing absolute rest the chair is superior to the bed.

* * *

• Alcoholism represents a human being who is escaping from intolerable stresses and strains.

* * *

• The best evidence indicates that in edema there is no primary trouble with the excretion of water. It is the sodium not the water. Plain water to a patient with edema may not only fail to increase the edema but if given a large enough amount of water, the edema will actually diminish.

* * *

• Interstitial edema may occur in the lungs without causing any rales.

* * *

• Prickly heat seems to be due to excess salt intake and is rapidly dispelled when large quantities of distilled water are administered.

* * *

• The most common bone disease is nonspecific and can be produced in experimental animal by withholding any one of 40 essential nutrients.

* * *

• It is becoming clear that the concentration of potassium is fully as important as that of sodium.

* * *

• In most patients requiring an intravenous solution, Ringer's solution would be better than normal saline solution.

* * *

• Overdosage of desoxycorticosterone may be fatal. This material must be given with great caution and every effort made not to give an overdose.

* * *

• Although sensitivity to allergens is, of course, the immediate cause of allergic rhinitis and allergic sinusitis, the sensitivity itself may be but a symptom of a chemical imbalance arising from dietary deficiencies.

* * *

• Our fighting forces against infectious diseases depend upon our protein intake.—J. F.

A Case of Splenic Neutropenia Complicated by Infectious Mononucleosis After Splenectomy

CARL I. WYLER, M. D., and EUGENE H. STERNE, Jr., M. D.

IT has been known for many years that derangement in the normal physiology of the spleen was closely associated with certain hemolytic or thrombocytopenic states, but it remained for Wiseman and Doan[1a,b] to emphasize that the white cells may be similarly affected. From these studies there has grown the concept of hypersplenism and there are a number of cases on record in which an acute or chronic neutropenic state has been shown to be secondary to overactivity of an otherwise normal spleen and which have been cured by splenectomy.[2a,b,c,d,e]

Doan and Starr-Wright[3] have pointed out that in congenital or acquired hemolytic anemia, thrombocytopenic purpura, and primary splenic neutropenia, a definite secondary decrease sometimes occurred in one or more of the cell types not primarily involved. There are therefore varying hematological syndromes ranging from a panhematopenia[3] to any combination of anemia, neutropenia, and thrombocytopenia.

If the diagnosis is based on the sound hematological principles as originally set forth by Wiseman and Doan,[1b] splenectomy is curative in most cases. The following case of primary splenic neutropenia and anemia was followed over a period of three years and resulted in an adequate clinical and hematologic recovery subsequent to splenectomy. The postoperative period was complicated by an illness strongly suggestive of infectious mononucleosis.

CASE REPORT

J. P., an eighteen-year-old student nurse, was seen on June 25, 1946, complaining of a painful swelling in the right axilla which had appeared subsequent to a hair follicle infection. Two months previously she had visited the personnel physician for an aphthous stomatitis and later for a cellulitis of the right knee following a minor trauma. The cellulitis healed uneventfully with wet dressings and penicillin. There was no history of exposure to any of the usual leucopenic agents.

At the time of admission she complained of severe headache, backache, and general prostration. Temperature was 101.6. Examination showed only a cherry-sized area of induration in the right axilla surrounded by moderate cellulitis. Initial white blood count, four hours after admission, was 1900 with 11 per cent neutrophiles. (Detailed blood studies done at this and on subsequent occasions are listed in table I.) Because of this finding, sulfamerazine, of which 2 grams had been given on admission, was discontinued. The axillary abscess eventually became fluctuant and was drained. Culture of this pus showed staphylococcus aureus. The fever, which ran an irregular course with peaks of 103°, gradually subsided over a period of eight days. At no time was the spleen palpable during this admission. Therapy, which included 1500 cc. of whole fresh blood, folic acid, and liver extract, had no effect on the neutropenia. However, she was discharged symptomatically well on the 19th hospital day.

The second admission was on August 1, 1946, because of a severe pharyngitis. Temperature was 101.6 and total leucocytes 2200 of which 28 per cent were neutrophiles. With penicillin therapy there was rapid improvement and she was discharged on the fourth day. An aspiration biopsy of the sternal marrow on this admission showed a normal cytology except for slight maturation arrest of the neutrophilic series.

Approximately one month later a soft and non-tender spleen became palpable one finger breadth below the costal margin. She was readmitted on September 16, 1946, to determine the cause of the persistent neutropenia. Blood studies on this occasion showed for the first time a macrocytic anemia. A bone marrow aspiration now showed, both on smear and fixed button preparations, a normoblastic hyperplasia without alteration in the leucocytic series. An adrenalin® test showed a rise in the leucocyte count from 2600 to 4400 one-half hour after the intramuscular injection of 1 cc. of adrenalin,® with a rise in the absolute neutrophile count from 550 to 2225.

Because of the patient's prolonged clinical

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course together with the blood studies, a diagnosis of hypersplenism seemed likely and, accordingly, on September 26, 1946, a splenectomy was performed by Dr. Louis G. Herrmann. At operation the spleen was described as "enlarged" and firm adhesions which bound it to the diaphragm made its removal difficult. After careful search a small accessory spleen was found and removed.

Postoperatively there was an immediate rise in the leucocyte count with a subsequent fall to 1800 the following morning. The convalescence was uneventful and there followed a gradual increase in total leucocyte and erythrocyte counts. She was discharged on October 10, 1946.

Four days later she was readmitted because of a brief history of chills, malaise, headache, and sore throat. Physical examination revealed tender swollen cervical lymph nodes and a moderate pharyngitis. Atypical young lymphocytes appeared in the blood smear for the first time on October 18, and the percentage of these cells continued to increase. The heterophile agglutination one week after admission was 1-8. This subsequently rose to 1-64 three weeks after admission. Two weeks later it was 1-32.

Clinically this admission was marked by high fever, severe sore throat, and persistent headache. In contrast to previous and subsequent attacks of pharyngitis, penicillin was unavailing. She was discharged on November 12, 1946, fever free, but weak and tired.

Since that time there have been no symptoms with the exception of four attacks of pharyngitis. She has continued to follow her nursing career, has regained her weight and strength, and feels well.

DISCUSSION

Despite the failure of the total and differential leucocyte count to return completely to normal, there are good reasons for classifying this case as ideopathic hypersplenism.

All the criteria currently necessary for the diagnosis of hypersplenism are developed as the result of primary or secondary hyperactivity of the reticuloendothelial system, particularly in the spleen.[1b,3] This case, which showed: (a) A severe neutropenia at the time of the first examination for axillary abscess, (b) persistence of the neutropenia for four months, (c) the development of a macrocytic anemia with slight reticulocytosis, (d) a bone marrow active for both myeloid and erythroid elements, but without evidence of maturation arrest or abnormal cell forms, (bone marrow aspiration of September 19), (e) the appearance of a palpable spleen while under observation, and (f) a suggestive adrenalin® test[3,4] fulfills these criteria. Further, the failure of any of the diseases known to produce neutropenia or secondary hypersplenism to appear over the three year period of observation, together with a spleen of normal anatomy, effectively eliminates such possibilities. For the reasons listed (a through f), a splenectomy was performed.

It is of interest to comment on the pathological appearance of the removed spleen. It is not intended to enter into a discussion as to whether the primary defect is essentially a mechanical one, i. e. hyperphagocytosis and sequestration of white and red cells within the structure of the spleen[1a,b] or rather, one of a distant humoral effect of the spleen on the bone marrow.[5a,b] Touch preparations made at the time of surgery and stained by supravital and Wright's methods, failed to reveal increased clasmatocytic activity as described by Wiseman and Doan[1b] though such of course may well have existed *in vivo*, or in the unexamined portions. Fixed sections of the spleen were interpreted as being within normal limits. The spleen was not greatly enlarged, although at the time of surgery some increase in size was noted by the operator. A weight of 165 grams may be normal or slightly heavy for a spleen in this small young woman.[6] Unquestionably, considerable reduction in size took place during the manipulation necessary to removal. The palpability of the organ developing during the course of illness certainly indicates increasing size, as is usual in this syndrome.

Also to be considered is the failure of the neutrophile count completely to return to normal values following splenectomy. That the ultimate stabilized total and differential leucocyte count is not entirely adequate in this instance is indicated by the recurring episodes of upper respiratory infection. Apart from these brief illnesses, however, the patient can be considered as well. This is demonstrated by the successful completion of her arduous nurse's training program, the maintenance of her usual body weight, and above all, her entire freedom from signs and symptoms of illness.

It is, of course, possible that a small amount of accessory splenic tissue may be present, and that the patient, therefore, still suffers from a mild degree of hypersplenism. While accessory splenic tissue was carefully searched for at the time of operation (and in fact one such small bit was removed), it is well known that small amounts may be exceptionally hard to find. However, the return of the preoperative anemia to normal, together with the sustained maintenance of normal erythrocyte count and the considerable increase in the number of neutrophiles suggest that no significant amount of such tissue can remain.

The possibility of some other disease causing the persistent moderate neutropenia need not now be seriously considered in view of a period of over three years without development of evidence of such disease.

The concept that the reticuloendothelial element of the spleen is the cell type actually responsible for this syndrome is an attractive one. If this be so, it is not too difficult to hypothesize that in removing the spleen we are removing

only a considerable portion of these cells, and that the residual neutropenia may be ascribed to overactivity of the remaining elements. Hyperreticuloendotheliosis, then, rather than hypersplenism, would better define the nature of the process.

POSTOPERATIVE COMPLICATION DISCUSSED

This case is made doubly interesting by the appearance, after three weeks of normal postoperative convalescence, of an acute febrile illness, clinically and hematologically indistinguishable from infectious mononucleosis. So far as can be determined from the literature and inquiry,[7a] infectious mononucleosis in a splenectomized person has not previously been reported. Clinically the presence of high fever, moderate prostration, severe pharyngitis, and considerable tender cervical adenopathy, together with the sudden and rapid increase in the leucocyte count from 3000 to the unprecedented level (for her) of 16,800 with approximately 50 per cent of the cells being atypical young lymphocytes of the type characteristic of infectious mononucleosis, are sufficient to make the diagnosis. Though the heterophile agglutination did rise from 1:8 to 1:64, it remains in the equivocal range. With an adequate clinical and hematological picture, a high titer of heterophile agglutination, though pleasing, is not considered essential to the diagnosis of infectious mononucleosis. Indeed one might speculate that the failure of the heterophile agglutination to reach a higher titer might conceivably be associated with a role of the spleen in antibody formation.

The uniqueness of this episode is made more significant when it is appreciated that such a cellular reaction and cervical adenopathy was associated with none of her many bouts of pharyngitis nor other infections. Further, while other febrile episodes responded excellently to penicillin therapy, on this single occasion, large doses of penicillin were entirely unavailing.

Though splenectomy itself is known to produce certain changes in the leucocyte count[7b] a

TABLE I

REPRESENTATIVE BLOOD COUNTS*

	Date	WBC.	N	L	M	RBC.	HG.	MCV.	Ret.	Pts.	Remarks
First Admission	June 25, 1946	1,900	11	43	43	4.12	13.8	94	.09	560	
	27	1,700	6	54	36						
	29	1,500	12	36	38						
	July 6	3,200	26	54	10						
	10	3,000	38	42	12						
Second Admission	Aug. 1	2,200	28	64	8	4.14	14.4		1.2	405	Bone marrow: slight neutrophilic maturation arrest.
	17	2,000									
	20	2,100	12	46	32						
Third Admission	Sept. 16	2,550	20	52	25	2.64	11.9	125	3.2	741	
	19	2,600	26	37	29	3.19	12	121	3.6	313	Bone marrow: normoblastic hyperplasia. Adrenalin® test done.
	23	2,600				3.08	12.7		1.5	498	
	26	2,400				3.38	13.2		1.3	560	Pre-operative
		5,700				3.26	12.8				After tying splenic vein.
		3,050				3.46	13.3				6 hours post-operative.
	27	1,800	8	16	71	4.19	16.5		2.6	1,118	Transfusions given.
	28	1,850	28	31	45	4.04	15.7		2.1	383	
	30	2,250	31	29	33	4.10	14.5		.5	625	
	Oct. 3	4,100	44	35	14	4.00	16	107	.2	616	
	7	6,200	43	38	8	4.10	16.1	109	1.2	1,113	
Fourth Admission	Oct. 15, 1946	2,400	9	32	46	3.89	15.1	99	.4	474	
	18	3,650	16	54	33	4.40	15.9		.9	748	9% Atypical young lymphocytes
	19	3,800	12	58	23						16% Atypical young lymphocytes
	21	6,100	13	81	5						51% Atypical young lymphocytes
	24	12,800	2	89	6						50% Atypical young lymphocytes
	28	16,800	8	87	5						42% Atypical young lymphocytes
	Nov. 4	9,900	8	77	14						20% Atypical young lymphocytes
	12	4,950	15	57	18	3.53	11.6		.8	840	2% Atypical young lymphocytes
	Dec. 26	6,100				4.55	13.5			728	
	Jan. 7, 1947	3,800	12	69	13	4.28	13.3	98	2.6	1,147	
	Feb. 27	3,100	14	55	23	4.85	12.8	84	1.2	805	
	May 17	2,750	10	80	10						Pharyngitis
	Dec. 4	5,250	10	90							Pharyngitis
	Jan. 2, 1948	4,350	26	66	2						
	Sept. 14	5,100	2	89	8						Pharyngitis
	Feb. 24, 1949	4,700	28	70	2						Pharyngitis
	April 18	3,750	31	41	13	4.38	13.8	91	1.3	438	

* Explanation of abreviations: WBC—Total white count; N—Neutrophils; L—Lymphocytes; M—Monocytes; RBC—Total red count in millions; HG—Hemoglobin in grams; MCV—mean corpuscular volume; Ret—Reticulocytes in per cent; Pts.—Platelets in thousands.

similar lymphocytic leucocytosis is nowhere reported from this cause alone.

SUMMARY AND CONCLUSION

1. A case of persistent neutropenia with anemia developing in a young woman and favorably modified by splenectomy is presented.

2. The concept of hypersplenism and possible reasons for failure of the complete hematological recovery are discussed.

3. The development of a postoperative complication strongly suggesting infectious mononucleosis is described.

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Protein Transport in Ocular Structures

The aqueous humor under normal conditions contains only traces of protein, but in certain pathological states aqueous protein becomes elevated and diffusion to other ocular structures occurs.

To evaluate and quantitate this phenomenon, human plasma albumin, and beef gamma globulin labeled with radio-active iodine were injected in experimental animals either intraocularly or intravenously. After a given time samples of ocular fluid and tissues were removed and radio activity determined.

—Albert M. Potts, Ph. D., M. D.,
Lorand V. Johnson, M. D.,
With the Technical Assistance of
Mildren Orchen and Doris Goodman,
Cleveland, Ohio.

Brief authors' abstract of paper presented at charter session of the Association for Research in Ophthalmology, East-Central Section, held in Cleveland, Jan. 10, 1950.

Radiography and Clinical Medicine

There are signs that the degeneration of clinical medicine is spreading with the aid and at the expense of radiology; it will ultimately bring radiology into disrepute. In a recent English newspaper it was stated that "one in every 20 people in Britain—or over 2,000,000—suffers from rheumatism. So it has been decided to mass-radiograph the joints of groups to ascertain the extent of the disease. When the unit is in operation it is proposed that every one of the 73,000 miners in the area will be X-rayed whether he has rheumatism or not." As pointed out by an orthopedic surgeon in a letter of appreciation of my opposition to this type of activity, "The whole thing is really an attempt on the part of some people to increase the number of attendances of their patients to astronomical figures and to increase similarly the work of other departments, and on the strength of this to increase the number of staff. The result of this is, of course, that with a very large staff the man in charge must be a very great person."

Mass radiography of the stomach is being used in one famous American hospital (surprisingly enough, in one to which a former physician brought great fame by his contributions to clinical medicine) for the detection of early malignant disease, and claims have been made of tests which reveal its presence. This might well incite further extensive mass radiological investigations. I believe one's energies in this direction could favourably be reserved until a cure for malignant disease has been discovered; then it could be applied enthusiastically with all skill.

There are other spheres in which the use of radiology not only fails to spare the patient pain but actually incites the infliction of pain by the performance of investigations, including surgery, which can be regarded as little else than meddlesome. I heard a professor of medicine at one of the universities urge that ventriculography was a useful, harmless, and painless method of investigating the cause of headaches. I saw the exhibition of radiographs of a patient with three aneurysms of the aorta, one of which showed radiographic evidence of erosion of the sternum and ribs. This patient sought the doctor because he had pain, and it should be our first duty to relieve that pain, yet this evidence did not incite the observer to pity, but to inject the aneurysm with opaque media to provide spectacular evidence of the extent of the lesions—knowledge which could not be of the slightest use to the patient, but which apparently satisfied the callous inquisitor. —James F. Brailsford, M. D., British Medical Journal, No. 4630, October 1, 1949.

Tuberculosis Abstracts

A Review for Physicians Issued Monthly by the National Tuberculosis Association

COUGH may be distressing and purposeless but more often it is a necessary and useful act. Cough can be produced voluntarily but more commonly it is a reflex response frequently reinforced by volition.

The act of coughing can be divided into three phases, namely: inspiratory, compressive, and expiratory. During the inspiratory phase there is a deep, often quick inspiration, followed by closure of the glottis. This results in an increase in intrapulmonary pressure, the compressive phase, immediately preceding expiration. During the expiratory phase the air is forced out with the production of characteristic cough sounds.

The function of cough is the removal of mucus, inflammatory exudate and other material from the air passages, or foreign bodies and other materials which may have been aspirated into the tracheobronchial tree.

Cough is a complex act which depends for its effectiveness on a number of factors. Important among these are bronchial movements which are dependent upon the ability of bronchi to elongate and increase their diameter during inspiration and to shorten and decrease their diameter during expiration. During the expiratory phase there is also forcible compression of the lung through action of the diaphragm and the chest wall.

The narrowing of the bronchus is greatly accentuated in asthmatics and in cases of pulmonary emphysema. It is observed least in persons with pulmonary fibrosis or anthracosilicosis. This compressive action forces secretions upward into the larger bronchi.

Ciliary function is important in the elimination of secretions from all portions of the airway except the terminal bronchioles. During acute infections with excessive or tenacious secretions, activity of cilia may be greatly impaired.

The establishment of a condition of tolerance may lessen or obliterate temporarily the reflex cough. This is commonly observed in patients with bronchiectasis who are able to go without coughing for hours. When cough is initiated volitionally they may evacuate several ounces of pus before again relapsing into a state of tolerance.

What are the causes of cough? In the common respiratory diseases such as pulmonary tuberculosis, pulmonary abscess or other pulmonary diseases, cough is a frequent symptom, and the cause can be demonstrated by roentgen study and physical examination. Excessive smoking and chronic alcoholism produce local congestive changes in the pharynx, larynx and tracheobronchial tree which give rise to cough. Exposure to dust and fumes exerts an unfavorable influence on the respiratory tract. An extrarespiratory cause of cough may be irritation of the external auditory canal, or nasal and pharyngeal obstruction. Cough may be associated with the taking of food or fluid, in paralysis of the larynx, or in laryngeal disease. Severe productive cough occurring when one changes position suggests either pulmonary abscess, bronchiectasis or empyema with bronchopleural fistula. In investigating this symptom a careful history of the onset and character of the cough, the precence and appearance of sputum, the time of occurrence and associated symptoms are important.

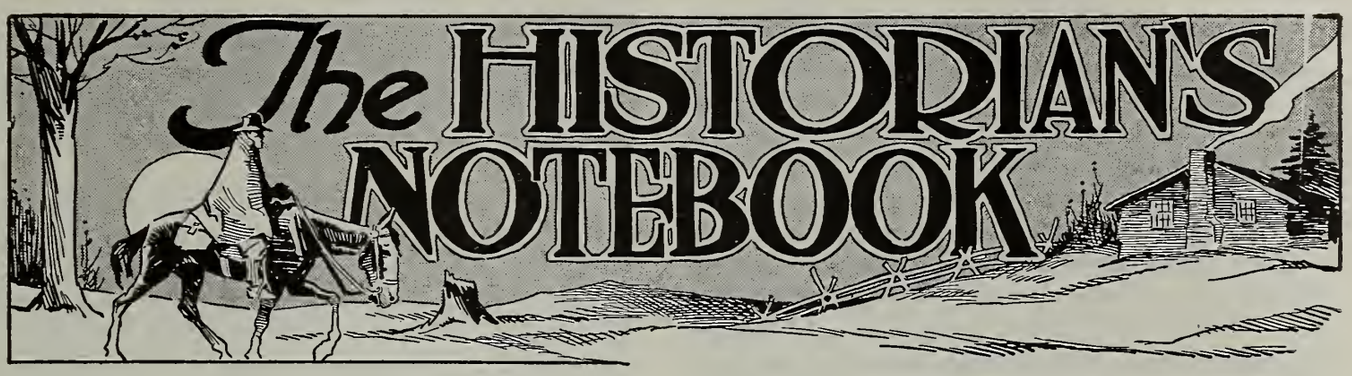
A study of the chest and the cardiovascular system should be made. The more common causes of cough should be excluded first. One should then proceed with an examination of the ears, nose, mouth, throat, laryngopharynx, larynx and neck, which can be done by any physician who has a reasonable knowledge of the upper air and food passages. The inveterate smoker should be encouraged to discontinue smoking and the worker in dust or fumes should minimize exposure in the absence of any definite localizing evidence of disease. Unexplained radiographic shadows or localized physical signs indicate bronchoscopy if the patient is an adult male. Cough with or without slight sputum is a common early symptom of bronchogenic carcinoma.

Bronchography is indicated if there is any suspicion of increased bronchopulmonary markings suggesting bronchiectasis. With a history of allergy, appropriate tests should be made.

The patient may be contented with the effects of a cough sedative or intralaryngeal instillations. The physician, however, should be interested in determining the cause of the cough.

Cough is necessary to rid the tracheobronchial tree of excessive secretions as in pulmonary abscess or bronchiectasis and in these narcotics should be used sparingly. In carcinoma, cough commonly is purposeless and is an early manifestation of bronchial irritation. In the postoperative case the cough "reflex" should not be suppressed. There must be adequate drainage of the tracheobronchial tree to prevent bronchial obstruction with secretions and postoperative pulmonary atelectasis.

If cough is purposeless, cough sedatives may be indicated. When cough is inadequate so-called stimulating expectorants are recommended. Inhalations of carbon dioxide and oxygen increase the quantity of sputum, and have been highly recommended.—*Cough, Louis H.. Clerf, M. D., The Mississippi Doctor, July, 1949.*



Ohio Physicians in the Nineteenth Century, a Statistical Study

PART II

FREDERICK C. WAITE, Ph. D.

(Concluded from August Issue)

APPROXIMATELY 2,000 medical degrees had been conferred by medical colleges in Ohio up to 1850 inclusive, when the United States census showed 4,274 physicians in Ohio. By no means all of these graduates of Ohio medical colleges remained in the state for practice. A conjecture is that not much more than one-fourth of the physicians in Ohio in 1850 held the degree of Doctor of Medicine.

Butler's directories of 1874 and 1877 make no pretense of indicating whether a physician held a degree or not. The first edition of Polk's **Medical and Surgical Register of the United States**, published in 1886, lists 4,947 physicians in Ohio of whom 3,257, nearly sixty-six per cent, are credited with a degree. The second edition, published in 1890, credits nearly seventy-four per cent of those listed with a degree. However, many names are marked with a symbol indicating that no reply was received to the inquiry of the compilers. Doubtless some of those who failed to reply held a degree so that it may be stated that in 1890 three-fourths or more of the practitioners in Ohio held the degree of Doctor of Medicine.

The first edition of **The Directory of the American Medical Association** was published in 1907 and lists 7,710 physicians in Ohio of whom 199, or two and six-tenths per cent, are not credited with a degree.

SECTARIAN PRACTITIONERS IN OHIO

No reliable figures for sectarian practitioners in Ohio are available until the appearance of medical directories in the final quarter of the nineteenth century. Thomsonians increased rapidly from 1830 to 1845 and the eclectics and physio-medicals, derived from the Thomsonians, began to appear before 1845. The homeopaths came a little later.

The History of Homeopathy and its Institutions in America, published by William H. King in 1905, states that 188 different homeopaths practiced in Ohio prior to 1860 and gives figures for four years, namely: 120 in 1857, 422 in 1875, 498 in 1885, and 968 in 1899. Comparison with figures from medical directories noted in the following paragraphs shows an exaggeration of claims over the information in the directories.

Statistics for sectarian practitioners in the state are derived from three medical directories. Butler's national medical directory published in 1874 lists 4,583 practitioners in Ohio. It carries symbols indicating irregular practice attached to 790 names, more than seventeen per cent. These are divided into three groups, namely: 241 homeopaths, 300 eclectics, and 249 who were suspected of being irregular in their practice. This third group included physio-medicals and men on the fringe of medicine such as clairvoyants, magnetic healers, and mesmerists. Doubtless it included some homeopaths and eclectics.

The second edition of Polk's national medical directory was published in 1890 and contains 6,469 names of physicians in Ohio of which 1,736, twenty-seven per cent, did not declare their system of practice, mainly from failure to reply to the inquiries of the compilers. There were 4,733 who did declare of which 959, or twenty-seven per cent, were sectarians, divided into 501 homeopaths, 393 eclectics, 51 physio-medicals, and 14 on the fringe of medicine such as botanics, magnetic healers, metaphysicians, and vitopaths.

DECLINE OF SECTARIANISM

The fifth edition of Polk's directory published in 1898 carries 8,231 names in Ohio of whom the system of practice is indicated for 7,991.

Of these 1,687, or more than twenty-one per cent of the total of declarers, were sectarians. The division is 914 homeopaths, 673 eclectics, 86 physio-medicals and 13 on the fringe of medicine, such as botanics, electropaths, hydropaths, osteopaths, and vitopaths. This directory carries a considerable number of men who are shown to have been graduated at sectarian medical colleges but declared themselves regular in practice. Only a very few graduates of regular medical colleges declared themselves sectarians. Sectarianism was decreasing in popularity with the laity. It declined during the final third of the nineteenth century, first affecting the botanics and physio-medicals. The last physio-medical college in Ohio closed in 1885. Rapid decline of sectarianism began about 1890 and was accelerated after 1900. The sectarian medical colleges could not keep up with improvements in medical education. A statistical study of physicians in Ohio in the first half of the twentieth century is desirable.

OHIO MEDICAL DEGREES CONFERRED DURING THE NINETEENTH CENTURY

Accurate compilation of the number of degrees granted by a medical college in each year involves two difficulties, lack of available complete files of catalogues and the practice of deferred degrees.

The majority of medical colleges soon after the close of each session published an announcement containing a list of students in the session just closed and a list of graduates at the recent commencement. Assumption that the latter contains the names of all graduates of that institution in that calendar year leads to errors.

A candidate for graduation might fail to receive his degree at the regular commencement from any one of four deficiencies, namely: not having reached his twenty-first birthday, not having completed the full thirty-six months of medical study, failure at examination, and negligence to pay his fees to the medical college. When such deficiencies were removed, sometimes involving a reëxamination, he received his diploma but his name would not appear in the announcement of the next year.

About 1870 many medical colleges began to give supplementary voluntary spring sessions in which deficiencies were removed with graduation at the end of the session. Some medical colleges, mainly sectarian, graduated two classes in each calendar year and issued only one announcement. At times the names of those graduated at the second commencement did not appear in the announcement of the following year. Therefore annual announcements are not reliable sources of the total number of graduates in any calendar year in any medical college.

Alumni catalogues, printed some years later, included the deferred graduates and must be examined to get the total number of graduates of a medical college in any year. These show twenty per cent of deferred graduates in some classes.

I have examined several hundred annual announcements and alumni catalogues of medical colleges in Ohio as sources of a table of all graduates of each institution in each year from 1821 to 1900 inclusive, differentiating degrees in course, honorary degrees, and *ad eundem* degrees.

This table, containing more than eight hundred entries, is too extensive to be presented orally or in print and has been condensed into a table showing the total number of degrees of all types conferred by all medical colleges in the state in each decade. This is followed by a list of the total number of degrees in different medical colleges of Ohio in the nineteenth century.

No figures are available for several fraudulent medical colleges in Ohio in the final quarter of the nineteenth century. Space is lacking for the story of these institutions. Their degrees were legal although usually worthless, and not recognized by licensing boards. Each fraudulent college in Ohio had a short life.

Table III

Degrees Conferred by Medical Colleges in Ohio in the Nineteenth Century by Decades

1821-1830,	114;	1871-1880,	4,385;
1831-1840,	514;	1881-1890,	4,494;
1841-1850,	1,384;	1891-1900,	4,145;
1851-1860,	2,478;		
1861-1870,	2,638;	Total,	20,152

This total includes 350 honorary degrees, 148 *ad eundem* degrees, and two degrees of Doctor of Obstetrics and Gynecology, a designation used for women by the homeopathic medical college in Cleveland in the eighteen fifties. It also contains 271 degrees from scattering records of botanic and physio-medical institutions.

The figures are complete for homeopathic institutions and contain all the graduates of regular medical colleges except one class at the Medical Department of the National Normal University at Lebanon in 1895. These classes were small and the number in this missing class is not more than twelve. The figures for eclectic institutions are reasonably complete and omit not more than fifty graduates.

The small increase for 1861-1870 over the preceding decade was due to the Civil War. The large increase for 1871-1880 over the preceding decade was due to the increase of medical students following every war and also was influenced by recent legislation in several states and by the fact that one holding a medical degree could obtain a license to practice without taking an additional examination before a

licensing board. The largest number of degrees conferred in Ohio in any calendar year was 594 in 1881. The largest single class was 122 graduates at the Medical College of Ohio in 1880.

Available statistics for the botanic medical colleges, which changed their designation to physio-medical in 1850, are fragmentary but are included in the totals in Table III as far as statistics have been found. Worthington Medical College is the only one for which figures are complete. It conferred eighty-eight degrees from 1832 to 1838. One such medical college operated in Cincinnati from 1840 to 1885 and a rival from 1859 to 1880. Each graduated two classes in many calendar years, making well over a hundred classes graduated. Scattering figures show as few as five and as many as thirty-seven graduates in a class. These institutions were at times prosperous and at other times decadent. No sources have been found to permit a close estimate of the total number graduated by this type of school in Ohio but it was a few hundred in addition to the 271 included in Table III and this conjectural figure should be added to the total in Table III to get the total number of medical degrees conferred in Ohio in the nineteenth century. A few honorary degrees of Doctor of Medicine conferred by colleges of arts having no relation to a medical college are not included in Table III.

The following list gives the total number of medical degrees of all types for each institution named in the nineteenth century. The list is arranged in three groups, regular, eclectic, and homeopathic, in each in order of founding. One small eclectic medical college existing during a few years in the eighteen fifties is omitted because of entire lack of statistics. The statistics of the botanic and physio-medical institutions are so fragmentary that they are not listed.

Table IV

Number of Degrees Conferred by Different Medical Colleges in Ohio in the Nineteenth Century

Medical College of Ohio, 4,182;
Cincinnati Medical College, 99;
Willoughby Medical College, 200;
Medical Department of Western Reserve College and University, 2,227;
Starling Medical College, 1,873;
Cincinnati College of Medicine and Surgery, 1,383;
Miami Medical College, 1,347;
Charity Hospital Medical College, 200;
Medical Department of Wooster University, 663;
Columbus Medical College, 599;
Northwestern Ohio Medical College, 31;
Toledo Medical College, 199;
Cincinnati Woman's Medical College, 23;
Medical Department of National Normal University, 61 plus;
Presbyterian Hospital Woman's Medical College, 23;
Ohio Medical University, 346;
Laura Memorial Medical College, 28;
Medical Department of Ohio Wesleyan University, 123;
Total regular degrees, 13,607 plus.
Eclectic Medical Institute, 3,461;
Eclectic College of Medicine and Surgery, 129;
American Eclectic Medical College, 159 plus;
Total eclectic degrees, 3,749 plus.
Cleveland Homeopathic Medical College (under seven names), 1,668;
Woman's Homeopathic Medical College, 17;
Pulte Medical College, 612;
Cleveland Medical College (homeopathic), 228;
Total homeopathic degrees, 2,525;
Total of three groups, 19,881.

These statistics are not claimed to be complete but are more extensive than any that have previously been assembled.

Dr. Samuel R. Geiser—1850-1924

Dr. Samuel R. Geiser was born in Missouri in 1850. After graduating from a literary College he came to Cincinnati in 1873, and entered Pulte Medical College from which he graduated in 1875 and practiced medicine in Cincinnati until almost the hour of his death. He served as professor of Materia Medica at Pulte College for 25 years. He gained national prominence as an authority on diseases of children and on Materia Medica and his services as a writer and lecturer on these subjects were in frequent demand. He took postgraduate work in London and Vienna.

Dr. Geiser became president of the staff at Bethesda Hospital and was honored at a testimonial dinner at his retirement having served for 25 years in that capacity. At his death in 1924, the members of the staff of Bethesda in their resolutions expressed unstinted praise and tribute from which we quote: "Clean, upright, honorable, unassuming and capable he held the esteem of the members of our staff during the long period of his presidency of twenty-five years. We cannot conceive it possible for any man, hedged about by our limitations, to have left a more honorable or efficient record than has our departed friend.

"We hope the inspiration of his noble life may ever be a guiding star to his fellow members of the staff who are left to carry on the great work of Bethesda Hospital—a work that has grown greatly since its modest beginning with Dr. Geiser and his bosom friend, Dr. Christian Golder, at the helm."

He became identified with every Homeopathic association and interest from local to national, and gave of his time, money and support for he was a staunch believer in Homeopathy. Quiet, gentle, cheerful, with a considerate bedside manner, he inspired hope and faith in his patients. He was a family doctor in every sense of the word. How sad that we have so few of them.—Lucy S. Hertzog, M. D., Chardon, Ohio.

A.M.A. Annual Session . . .

House of Delegates at San Francisco Session Takes Actions on Many Matters and Policies of Utmost Importance to Medical Profession

SEVERAL matters of far-reaching importance to the medical profession were transacted at the Annual Session of the American Medical Association in San Francisco, June 26-30.

Because the official proceedings of the House of Delegates had not been made available in time, only a brief summary of these activities was reported in the August issue of *The Ohio State Medical Journal.* The following paragraphs contain further summaries of some of the more important actions taken by the House of Delegates. The complete proceedings are contained in *The Journal of the A. M. A.* beginning with the July 15 issue.

One of the more important policy matters decided by the House of Delegates was adoption of a revision of the "Hess Report" or report of the Committee on Hospitals and the Practice of Medicine dealing with the physician-hospital relationship. This report, because of its importance to the medical profession, is given in full on page 899 of this issue.

JUNIOR A. M. A.

The House of Delegates approved a report of the Council on Medical Education and Hospitals which recommended that the A. M. A. not lend its support to the activities of the Association of Interns and Medical Students, for reasons outlined. The complete report is published beginning on page 992, *Journal of the A. M. A.*, July 15.

Prominent among reasons for disapproval of the organization was its affiliation and association with Communist and Communist Front organizations, and its reputation of being a left wing organization. Among factual information reported by the Council was that the Association of Interns and Medical Students at its 1948 convention had endorsed the principle of compulsory health insurance.

In pointing out that the organization has enrolled not more than 5 per cent of the total number of medical students, interns and residents, the report further states that "probably the great majority of the members of the association are well intentioned individuals . . . ."

The House at the same session approved establishment of a junior American Medical Association as proposed by the Board of Trustees. In its proposal, the Board recommended that the organization be limited to medical students; that county medical societies be encouraged to offer special memberships to interns; that the basis of the organization be local student societies with advisory committees; that an executive secretary be appointed with offices at the A. M. A. Headquarters; that the national organization have representation (without vote) in the House of Delegates.

MEMBERSHIP AND THE JOURNAL

A resolution proposing a single membership classification in the A. M. A. and including *The Journal of the A. M. A.* as part of the membership benefits was introduced by Dr. Carl A. Lincke for the Ohio delegation.

The reference committee considered this resolution in conjunction with two other similar resolutions and reported favorably on including *The Journal of the A. M. A.* as part of membership benefits. The House approved the committee's recommendation that beginning January 1, 1951, membership dues shall include the subscription to *The Journal.*

In regard to a single membership classification, the committee recommended (and the House concurred) that the matter be referred to the Interim Committee on Amendments to the Constitution and By-Laws for prolonged study and report at the next session of the House.

In another action, the By-Laws of the A. M. A. were amended to include "Active Members" among those permitted to register at sessions of the Association.

GENERAL PRACTICE

The House approved a report of the Committee on General Practice which enumerated a number of pertinent observations, opinions and recommendations. The Committee "recognizes a change in the attitude toward and the emphasis on general practice in the past three years. . . . that medical students and interns are planning in increased numbers to engage in general practice, that more medical schools are aware of their responsibility for the training of adequate numbers of students for general practice and that the public is becoming increasingly aware of the need for the family and personal health counselor . . ."

"It is the opinion of the Committee," the report continues, "that an insufficient number of general practitioners are being trained to fill the basic needs for adequate care for the American people and that there is still an overemphasis on the training of specialists. It is

realized by leaders responsible for medical education and distribution of medical care that the best interests of the American people are served, economically and medically, when a balanced medical community is established with a foundation of 60 to 80 per cent of well trained general practitioners, with highly trained specialists skilled in the narrower branches of medicine readily available."

The Committee recommended the inclusion of general practitioners as clinical instructors in medical schools; a series of lectures or panel discussions on the art of medical practice during the junior and senior years, and preceptorships sponsored and controlled by state medical societies and medical schools. It further commended the Council on Medical Education and Hospitals for its work on development of general practice residencies and recommended that the Council make every effort to have these facilities expanded. In this respect, it recommended that the Council consider use of small general hospitals for training.

The Committee expressed its opinion that a higher quality of specialist would be obtained if the candidate for any field of specialization were taken from the ranks of the general practitioner with several years of practice.

The Committee further recommended a continuance of the integration of general practitioners into hospital staffs.

MEDICAL EDUCATION

The House adopted the report of the reference committee which approved a supplementary report of the Council on Medical Education and Hospitals pertaining to a revision of certain sections of the "Essentials of Approved Residencies and Fellowships." The complete report is published beginning on page 995, *Journal of the A. M. A.*, July 15.

The House adopted a report of the reference committee which commended the American Academy of General Practice for the initiative it has shown in preparing the *Manual on the Establishment and Operation of a Department of General Practice in Hospitals* and suggested that it be made available to hospitals which are planning to develop general practice sections.

The House rejected a resolution which would have instructed the Advisory Board for Medical Specialties to authorize no more new specialty boards without specific approval of the House of Delegates, as being out of the jurisdiction of the A. M. A. At the same time, however, it suggested that the Advisory Board for Medical Specialties and the Council on Medical Education and Hospitals exercise the greatest discretion before approving any additional specialty boards to avoid an overabundance of specialty boards.

The House adopted a resolution disapproving the practice of certain hospitals making specialty board ratings a requirement for appointment or promotion.

MASS SURVEYS

In regard to exfoliative cytologic diagnostic procedure, the House adopted the following resolution:

"Whereas, The American Medical Association wishes to promote the diagnosis of cancer in its early stages; and

"Whereas, It wishes to support the application of such diagnosis throughout the profession; and

"Whereas, It believes that the diagnosis of cancer should be a function of the local private practice of medicine; therefore be it

"Resolved, That the American Medical Association endorses the use of all recognized facilities for the initial diagnosis of malignant disease, including the examination of tissues, exudates and bodily excretions. In the case of mass surveys, the American Medical Association believes that this work should be in the hands of qualified private practitioners; and be it further

"Resolved, That these surveys be conducted at the local level and under direction of the county or state medical society."

The House adopted a resolution approving of self-testing for sugar in diabetic detection.

PUBLIC RELATIONS

The Board of Trustees reported that since the December meeting of the House, the Washington Office had been moved into much larger and better equipped quarters and that the personnel also had been increased. Dr. Joseph Lawrence, director, is now assisted by two physicians, one lawyer, one staff writer and one administrative assistant.

At direction of the House of Delegates, the Board appointed the Coordinating Committee on Legislation whose duties are the facilitating of the activities on legislative matters and the dissemination and distribution of legislative information throughout the various states.

The Board of Trustees reported that it had extended the contract with Whitaker & Baxter whereby the national educational campaign will be continued during the year 1951, but at a "greatly decreased tempo."

OTHER ACTIONS

The Board of Trustees reported continued progress on the part of the Commission on Chronic Illness for which the A. M. A. provides office space. The Commission is composed of approximately 35 members representing the general public, industry, labor, agriculture, education, religion, the social sciences, journalism, health and welfare as well as medicine.

The House adopted a resolution directing the Council on Medical Service to study the feasibility of including payment for nursing service in

Voluntary Health Insurance Plan Benefits and to report its findings to the House at the next session.

It was suggested that state medical examining boards and the Federation of State Medical Boards of the U. S. give special study to the situation with respect to displaced physicians with the idea of framing special regulations to meet it.

The House adopted a request that the Council on Scientific Assembly be requested to consider again the establishment of a Section on Military Medicine and Surgery and a recommendation that the Council on Scientific Assembly provide time on the program to be devoted to the medical and health problems of our national defense and security.

The Interim Session of the A. M. A. will be held in Cleveland, December 5-8, and not in Denver as previously announced, according to a report of the Board of Trustees.

The Board of Trustees reported that it had considered feasibility of publishing a bulletin for the Woman's Auxiliary and had decided against doing so, primarily because members of the Auxiliary did not desire such a publication.

St. Luke's Hospital, Cleveland, Schedules Weekly Symposia

The fall term weekly symposia, sponsored by the Postgraduate Committee of Saint Luke's Hospital, Cleveland, will be held beginning on Wednesday, September 20.

Each symposium is planned for thorough, practical coverage in diagnosis and treatment and is designed to be of general interest. Those attending may secure credit toward General Practice Boards, Dr. Joseph E. Brown, chairman of the Postgraduate Committee, said.

Registration fee for the full term is $10, payable in advance upon registration.

The following subjects have been announced. All symposia are on Wednesday afternoons:

Sept. 20—"Ear, Nose and Throat in General Medicine."
Sept. 27—"Arthritis."
Oct. 4—"Anesthesia in General Practice."
Oct. 11—"Peptic Ulcer."
Oct. 18—"Backache."
Oct. 25—"Congenital Heart Disease."
Nov. 1—"Sequela of Subdural Hematoma."
Nov. 8—"Endocrinology."
Nov. 15—"The Kidney."
Nov. 29—"Allergy in Children."
Dec. 6—"Occupational Hazards."

Registration may be made or additional information obtained by addressing the Postgraduate Committee at the hospital, 11311 Shaker Blvd.

Medina Hospital Program Scheduled October 4

The Medical Staff of the Medina Community Hospital will present its third annual Hospital Day at the Westfield Country Club, LeRoy, on October 4, starting with a scientific session at 2 p. m.

The afternoon program includes the following features to be presented by members of the Cleveland Clinic Staff:

"Diagnosis of Neurological Lesions," Dr. W. J. Gardner;

"Discussion and Moving Pictures of Recent Advances in the Treatment of Hypertension," Dr. A. C. Corcoran;

"Peptic Ulcer," Dr H. R. Rossmiller;

"Recent Advances in Diagnosis and Treatment of Thyroid Gland Disease," Dr. G. W. Crile, Jr.

A social hour will be held beginning at 5 p. m. with dinner following at the Westfield Inn at 6:30 p. m.

"Life Under the Sea," colored moving pictures taken by Dr. and Mrs. Crile on their deep sea diving expedition to the West Indies will be shown.

During the afternoon session, wives may play golf or have a session of bridge. An "antiquing" trip also will be conducted for those interested. All doctors and their wives are invited.

Sixth District Postgraduate Day Scheduled October 4

The Sixth Councilor District Postgraduate Day will be held on Wednesday, October 4, in Canton, it was announced following a meeting of the District officers on August 13.

Registration will be held from 9 to 9:30 a. m. at the St. Francis Hotel. First Session will be from 9:30 a. m. to 12 noon and the Second Session from 1:30 p.m. to 4:30 p. m. The Banquet will begin at 6:30 p. m. in the Hotel Onesta, followed by an evening speaker at 7:30 p. m.

A panel of outstanding medical speakers has been secured for the session. The following speakers will each present two medical topics: Dr. Robert Durham, internist, Ford Hospital, Detroit, Mich.; Dr. A. L. Hoyne, pediatrician, Chicago, Ill.; Dr. Phil Thorek, surgeon, Chicago; and Dr. H. A. Power, obstetrician and gynecologist, Pittsburgh, Pa.

A registration fee of $6 will include the banquet. Advance registrations can be made by contacting Mr. E. M. Sprunger, executive secretary of the Stark County Medical Society, 400 Fourth St., N. W., Canton 2.

The Hess Report . . .

Physician-Hospital Relationship Interpreted as A.M.A. Delegates Approve Findings of Committee on Hospitals and Practice of Medicine

FOLLOWING is the revised and amended draft of the so-called "Hess Report" as it was adopted by the House of Delegates of the American Medical Association at the San Francisco Annual Session in June. The report derives its name from Dr. Elmer Hess, of Erie, Pa., chairman of the Committee on Hospitals and the Practice of Medicine which formulated it and later revised it.

The report is a declaration of principles in regard to the relationship between physicians and hospitals or other corporate organizations. Its history is outlined in the first few paragraphs.

The text following is the final draft of the report containing amendments and revisions made on the floor of the House, as it appeared in the official proceedings, pages 1090-1092, *Journal of the A. M. A.*, July 22.

* * *

AMENDED REPORT OF THE COMMITTEE ON HOSPITALS AND THE PRACTICE OF MEDICINE

In June 1949, the House of Delegates approved a report, as revised by the Reference Committee, submitted by the Committee on Hospitals and the Practice of Medicine. Subsequent to this meeting and after receiving a legal opinion from the Association's general counsel, the Board of Trustees referred the entire report back to the House with specific recommendations concerning certain portions of the report.

PRIOR ACTION

In December 1949, the House of Delegates approved the following resolution in regard to this report:

". . . . that in the interests of maintaining high professional standards and protecting the public health, the House of Delegates reaffirms the philosophy underlying and the principles enunciated in the Hess Committee report, and that in view of the possible legal technicalities, the activation of the Hess Committee report be deferred until after the next meeting of the House of Delegates and that between this and the next meeting of the House of Delegates the original report be re-referred to the original committee or reasonable facsimile thereof and that the committee be instructed to consider ways and means of activating the original report in accordance with the principles expressed therein and in accordance with legal considerations which must be present."

In view of this resolution of the House of Delegates, the Correlating Committee on Extension of Hospitals and Other Facilities of the Council on Medical Service consisting of the original members of the Committee on Hospitals and the Practice of Medicine plus two additional members appointed by the Council has undertaken to restudy the problem and rewrite the report in such manner as to meet the directives of the House of Delegates.

In addition to studying the original report, the Committee requested expressions of opinion on the part of the various specialty groups and of the various hospital associations and also granted them permission to have representatives appear before the Committee if they so desired.

CORPORATE PRACTICE

The Committee wishes to report again that so far as it can determine, on the basis of a study made by the Bureau of Legal Medicine and Legislation of the American Medical Association, as a matter of law the corporate practice of medicine is illegal in most states. In almost all instances the classic example given by the courts of the type of corporate practice of a profession that is illegal is the instance in which a corporation hires a professional man and then sells his services to the public on a fee basis for the profit of the corporation. Such exceptions as there are refer to statutory legislation in several states permitting certain modifications of this general law. It must also be remembered that fee splitting with a corporation is just as unethical as fee splitting with another physician.

In addition to being guided by the laws of the various states, physicians in their relationships with hospitals must be guided by the Principles of Medical Ethics of the American Medical Association. Those sections of the Principles which have a distinct bearing on these relationships are as follows:

Chapter I. Sec. 3. "Groups and Clinics—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession."

Chapter III. Article VI. Sec. 2. "Conditions of Medical Practice—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the

patients concerned might be deprived of immediately necessary care."

Chapter III. Article VI. Sec. 3. "Contract Practice—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

"Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered."

Chapter III. Article VI. Sec. 6. "Purveyal of Medical Service—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people."

In conclusion, the Principles of Medical Ethics states: "These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community . . ."

On page 31 of the Constitution and By-Laws as printed in the Handbook under the Duties of the Judicial Council, is found the following:

"The Council shall have jurisdiction on all questions of medical ethics and the interpretation of the laws of the Association.

"The Council at its discretion may investigate general professional conditions and all matters pertaining to the relations of physicians to one another and to the public, and may make such recommendations to the House of Delegates or the constituent associations as it deems necessary.

"The Council shall have authority to request the President to appoint investigating juries to which it may refer complaints or evidence of unethical conduct which in its judgment are of greater than local concern. Such investigating juries, if probable cause for action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against the accused before the Judicial Council in the name and on behalf of the American Medical Association. The Council may acquit, admonish, suspend or expel the accused."

REMOVAL FROM LIST

If and when a physician is found to be unethical by the proper authorities as established through channels specified in the Constitution and By-Laws, and he is still retained on the staff of any hospital approved for resident or intern training by the Council on Medical Education and Hospitals, it shall be the duty of the Judicial Council to request the Council on Medical Education and Hospitals to show cause as to why that Council should not remove such hospital from the approved list under the assumption that the hospital is just as unfit for the training of young physicians for unethical reasons as it is unfit because it may not or does not have proper filing systems for its laboratory or clinical records.

Another matter which the Committee believes pertinent as regards the problem of physician-hospital relationships is the set of principles prepared by the Council on Professional Practice of the American Hospital Association (Robin C. Buerki, M. D., Chairman) and approved in 1946 by the Board of Trustees of the American Hospital Association, the American College of Surgeons, representatives of the various specialty groups (anesthesiology, radiology, and pathology), and the Council on Medical Education and Hospitals of the American Medical Association.

These Principles of Relationship Between Hospitals, Radiologists, Anesthetists and Pathologists emphasize that the primary obligation of both physicians and hospitals is to serve the best interest of the patients. This the Committee believes leads to a fundamental principle that the decision as to the ethical or unethical nature of practice must be based on the ultimate effect for good or ill on the public as a whole. These principles also recognized the basic fact that all of the various questions involved in the relationship between physicians and hospitals, both legal and ethical, must be considered in the first instance at the local level because of the various differences which of necessity exist in the many sections of the country. Again, the Committee believes that this gives us another fundamental principle, that, consonant with established principles of medical ethics, local conditions must decide the various arrangements and conditions of practice in reference to both hospital facilities and medical personnel and their relationships.

'HOSPITAL SERVICES' ONLY

One of the factors that have aggravated physician-hospital relationships is the inclusion of medical services in the contracts of voluntary hospital service plans. The medical profession is fostering voluntary health insurance, and we believe that nothing should be done to disturb this very important and essential program. However, the American Medical Association has reaffirmed many times through its then Bureau of Medical Economics, its Judicial Council, and the House of Delegates the principle that hospital service plans should exclude all medical services, and the contract provisions of such plans should be limited exclusively to hospital services. At the same time, so that there would be no misunderstanding as to which services should or should not be included, the House of Delegates has stated that ". . . if hospital serv-

ice is limited to include only hospital room accommodations, such as bed, board, operating room, medicines, surgical dressings and general nursing care, the distinction between hospital service and medical service will be clear." (Proceedings of the San Francisco Session of the House of Delegates, 1938, p. 31.) Furthermore, past actions of the House of Delegates give the Committee every reason to reiterate that radiology, anesthesiology, pathology and physiatry constitute the practice of medicine.

In order to initiate a method for remedying this situation, it is recommended that Blue Shield and Blue Cross be requested to cooperate to the extent of writing all new contracts in such a manner that Blue Shield will cover insurable medical services and Blue Cross will cover insurable hospital services. Your Committee believes that the professional and hospital authorities and the voluntary prepayment plans will cooperate in furthering these recommendations.

DOCTORS' INTERESTS ALL INCLUSIVE

The Committee believes that since the physician and hospital are interdependent, it is incumbent on both to be interested in all phases of their scientific and financial relationships. This means that the professional staff of the hospital has very definite responsibilities toward not only other members of the professional staff, whether active or courtesy, but also toward hospital management. The recommendations of the staff concerning medical matters are usually accepted by the management of the hospital through its board of managers or trustees. It must also be remembered that to be approved for residencies in specialties by the American Medical Association and the American College of Surgeons, certain requirements are mandatory to the institution, among them adequate pathologic and radiologic coverage. As a rule, the staff of a hospital elects an executive committee or works under an appointed executive committee to advise the lay officers of the institution on purely professional matters, and recommends who may or may not use the institution for professional work. Unfortunately, in many instances, the financial problems of the lay hospital management have been no affair of the staff or of its professional executive committee. This is wrong and probably the cause of most of the differences of opinion between physicians and hospital management. The financial problems of an institution in which a physician does his professional work are definitely of importance to him and to the professional staff, and the proper consideration must be given to these problems if the hospital is to work efficiently and remain the workshop of the physician, and without proper facilities the services rendered to the public are in jeopardy and these public services are the all-important function of both hospital and staff.

Every professional man on the appointed staff should have a voice in the professional management of the institution. The pathologist, roentgenologist, anesthesiologist and physiatrist, as well as the other professional staff members, should have equal standing as active members of the staff with all the rights and privileges pertaining to other members of the staff of equal standing. The chiefs of these departments should be nominated and appointed in the same manner as are the chiefs of other major departments in the same hospital.

The revised Principles of Medical Ethics has been written with all of these various factors in mind and is broad enough to cover all possible ethical physician-hospital relationships. The Constitution and By-Laws of the American Medical Association distinctly covers methods of procedure for all persons who have a complaint so that they may approach the Judicial Council. The functions of that Council are specifically delineated.

FIRST ON LOCAL LEVEL

For the purpose of activating this report, the Committee has the following suggestions:

In the event of a controversy between physician and physician, or physician and hospital management, on these problems, it is recommended that, since local conditions must be taken into consideration, these problems be resolved insofar as possible at the local level.

The Committee believes that there can be no exploitation of the doctor or of the hospital if everyone concerned in management and on the professional staff will work together to supply the greatest possible good quality medical and hospital services to the public. In any given controversy, every effort should first be made to settle the matter at the staff-management level. In case of failure to settle the controversy at this level, assistance of the county medical society should be requested. If, then, it cannot be resolved it should be submitted to a committee of the state medical association for advice and recommendation. If problems cannot be solved at the staff-management level, through the county medical society, or through the state medical association, the Constitution and By-Laws of the American Medical Association provides that ". . . the (Judicial) Council may, at its discretion, investigate general professional conditions and all matters pertaining to the relations of physicians to one another and to the public, and make such recommendations to the House of Delegates or the constituent association as it deems necessary."

COUNTY AND STATE COMMITTEES

To implement the settlement of such controversies, it is recommended that each component medical society and each constituent state and territorial medical association appoint a Committee on Hospital and Professional Relations. This committee should be available to receive complaints from any physician, hospital, medical organization, or any other interested

person or group with reference to professional or economic relations existing between doctors of medicine and hospitals. On receipt of such complaint by such a committee the matter should be investigated and acted on in such manner as will best effect adjustment of the complaint.

Your Committee has already communicated with every state in the Union requesting that a Committee on Hospital and Professional Relations be created at the state level to assist similar committees at the county society level in solving these disagreements wherever they arise. Many states have already established these committees, and they are functioning.

Another approach that should not be neglected in activating this report is that of the local and state hospital associations. Most of the states and many communities have hospital associations providing direct representation for the hospitals within their areas. It seems reasonable to assume that state medical associations and component county medical societies could well effect liaison with these organizations in the settlement of problems involving physician relationships.

The following principles are additional guides to individual physicians, county medical societies and state medical associations:

1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.
2. Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.
3. The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine.

Finally, in order that progress regarding the activation of the report may be followed, the Committee suggests that the House of Delegates authorize this Committee to keep in touch with the Committees on Hospital and Professional Relations appointed by the county medical societies and the state medical associations and report on such progress at the next annual meeting.

ADDENDUM: SUPPLEMENTARY REPORT OF THE COMMITTEE ON HOSPITALS AND THE PRACTICE OF MEDICINE

The Committee believes that if the following pattern were followed the possibility of solving any controversy between physician and hospital would be greatly improved:

When a physician believes he has a legitimate complaint against hospital management, he should first attempt to solve the difficulty at the staff level. And it is incumbent on the medical staff to assist in arriving at a fair and proper solution.

If no solution is reached at this level, the physician should appeal to the appropriate committee of his county medical society for advice and assistance. The county medical society committee should develop methods for contacting hospitals, management and boards, as well as local associations representing hospitals, in order that all sides of the controversy may be understood and personality difficulties minimized.

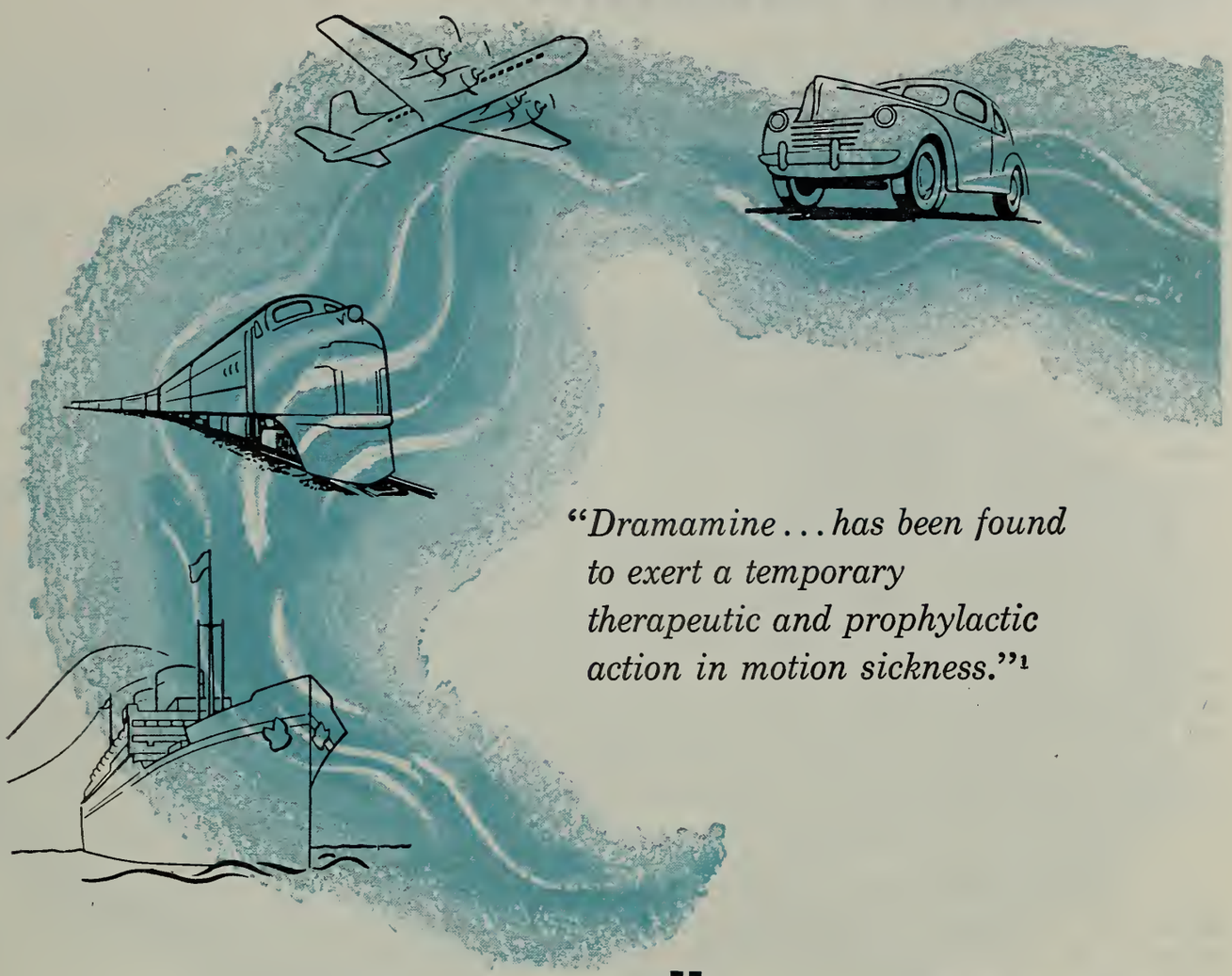
When a solution seems impossible through the good offices of the county medical society, mechanisms should be available for presentation of the matter to the state medical association of which the physician is a member. Here again, for the purpose of receiving all available facts and opinion, the state medical association should develop liaison with the state hospital association.

To facilitate the consideration and mediation of physician-hospital controversies, specific authorization to handle such matters should be given to some committee of both county and state medical societies. In the larger county societies and the state associations this function could be best carried out through a special committee created for just this purpose. It should be the function of such committees to mediate differences in the light of the existing state laws, the Principles of Medical Ethics, and the best interests of the patients.

The services of the Correlating Committee on Extension of Hospitals and Other Facilities of the Council on Medical Service, working with a similar committee of the American Hospital Association, should be available to study and assist in solving physician-hospital problems which seem unsolvable at the local and state levels. For formal opinion or adjudication, however, the portfolio should be presented to the Judicial Council.

(The recommendation of the reference committee that the supplementary report be referred to the Judicial Council was approved by the House of Delegates.)

The first of the A. M. A. documentary programs is scheduled to be broadcast over the National Broadcasting Company network on Labor Day. The program is built around the A. M. A. Council on Industrial Health, and will portray the progress which has been made in industrial health. It recognizes the broad modern concept of industrial health which takes into account the economic, social and emotional welfare of workers as well as their physical well-being.



"Dramamine . . . has been found to exert a temporary therapeutic and prophylactic action in motion sickness."[1]

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1. Council on Pharmacy & Chemistry: New and Non-official Remedies, 1950, Philadelphia, J. B. Lippincott Co., 1950, p. 460.

*Trademark of G. D. Searle & Co., Chicago 80, Ill.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Washington Roundup . . .

Some Notes on Medical and Health Proposals and Developments in the Capital with Observations on Other Matters of Vital Interest to Doctors

A GOVERNMENT survey, made public late in July, is evidence that only about one-third of the money spent for health purposes goes to physicians in payment for their services. The report, covering 1949, says that about 1.2 per cent of all money spent by American families for consumer goods and services goes to doctors of medicine. On the other hand, 2.06 per cent of the total goes for other health expenses.

During the 12 months, physicians received $2,267,000,000. During the same period Americans were spending $1,391,000,000 on drugs, $105,000,000 on private nurses, $416,000,000 on ophthalmic products and orthopedic appliances and $1,631,000,000 on private hospitals. If non-private hospitals were included—Federal, state and local—the hospital cost figure would be several times as high, with subsequently greater difference between payments to physicians and payments for other health services.

* * *

Informal weekly conferences are bringing together the Federal government's top medical officials in the closest approach yet to military-civilization coordination. The meetings are being held in the office of Dr. Richard Meiling, Columbus physician now serving as the Defense Department's medical director. The meetings are attended by the surgeons general of the Army, Navy and Air Force and by special invitation of Dr. Meiling include the surgeons general of the Public Health Service and the Veterans Administration. This brings together at least once a week the six physician-officials responsible for the entire Federal government medical program.

* * *

The Civil Aeronautics Administration's list of 350 ambulance planes, giving capacity and facilities (oxygen, etc.) and day and night phone numbers of owners, is now available to county medical societies.

* * *

In the first 15 years of the Social Security Act, 24 billion dollars has been paid to individuals —over two-and-a-half billion for care of dependent children; nearly 10 billion to needy aged; close to eight billion in unemployment insurance; 287 million to the blind; nearly three-and-one-half billion in old age benefits.

* * *

The bill which would have given Federal aid to medical education (H. R. 8886) was considered at an executive session of the House Interstate and Foreign Commerce Committee. A vote was taken on motion to table the bill which carried nine to eight. Staff members of the committee interpret this to mean that the legislation will not be considered for the rest of this session. The committee on two prior occasions refused to report this legislation by a one vote margin.

* * *

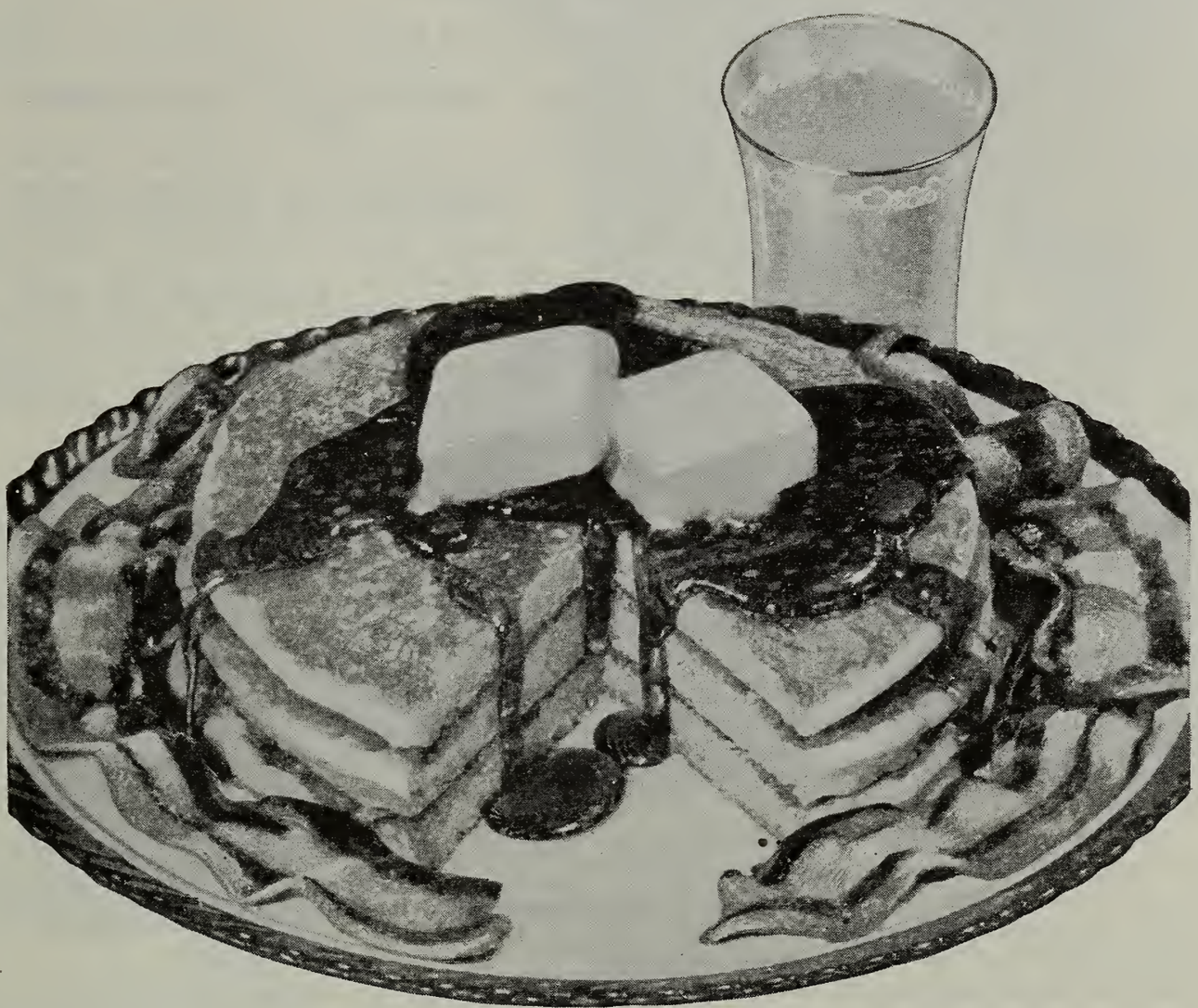
The Armed Forces' Medical Advisory Committee, known as the Cooper Committee, has recommended that military medical departments concentrate on support of combatant forces as their primary mission. Since the last war, officials have had this subject under study. Last fall Secretary of Defense Johnson ordered the three medical services to put primary emphasis on care of military personnel. However, he later explained that military dependents would continue to receive attention.

* * *

The energetic Chronic Disease Division of Public Health Service is readying itself for emergencies. The division's top officials are looking toward a fast change of emphasis, under which they would break off long-range surveys and programs and concentrate on problems directly related to the emergency. This shift still is in the talking stage, but the people involved believe it is pretty likely to take place, and soon. It was this division which perfected a multiphasic screening program for rapid mass-testing for such major diseases as tuberculosis, diabetes, venereal diseases, etc. Such a process undoubtedly would be an important time-saver in some phases of military inductions, as well as large industrial plants. Chronic disease officials also are working out plans for greater cooperation with other agencies, government and private, to meet the new problems.

* * *

On September 1, a comprehensive system of prepaid insurance for doctor bills starts in Maryland. Eligible are subscribers to the Maryland Hospital Service (Blue Cross) who constitute 40 per cent of the state's population. The comprehensive plan (Blue Shield) will supplement the Blue Cross's hospital plan by paying standard fees to physicians. If the family income is under $3,600 per year, the doctor may collect only the standard fees. If the family's income is higher, the doctor may charge in excess of the standard rates and collect the difference from the subscriber.



A Real American Breakfast

That a nutritious breakfast providing generous amounts of high quality protein prevents late morning hypoglycemia has been amply demonstrated. As shown by Thorn and co-workers,[1] and later confirmed by Orent-Keiles,[2] ". . . breakfast high in protein and low in fat and carbohydrate was followed by an improved sense of well-being and no symptoms of hypoglycemia."

Meat for breakfast—ham, sausage, bacon, breakfast steaks—is an appetizing means of increasing the protein content of the morning meal. Its biologically complete protein contains all essential amino acids, and serves well in complementing less complete proteins from other sources. Furthermore, muscle meat is an outstanding source of B complex vitamins and of iron.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

(1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., Ann. Int. Med. 18:913 (June) 1943.
(2) Orent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

American Meat Institute
Main Office, Chicago... Members Throughout the United States

Poor Relief Problem . . .

Situation Regarding Financing of General Relief and Old Age Pensions Is Acute; What Is Cause? What Are Facts? What Is Remedy?

SITUATIONS which have been developing in many communities of the state with respect to the furnishing of poor relief and pensions for the aged indicate that a real crisis looms.

Many areas do not have adequate funds available to meet general relief needs, including medical and hospital care. The same situation prevails so far as state assistance is concerned.

Allowances to recipients of aid to the aged have been insufficient in many instances, welfare officials and recipients have charged.

SOME PERTINENT QUESTIONS

How much is being spent in Ohio on these services? What has caused the existing problems? What are the solutions, if any? How far can the state go in supplying public funds for such purposes? Are local communities meeting their responsibilities?

These are some of the questions which are being asked.

The answers to some of them, in addition to some pertinent statistics and other data on the matter, generally, will be found in the following article and tables, published in a recent issue of *Public Welfare in Ohio Today*, official magazine of the Ohio State Department of Public Welfare:

"Numerous inquiries have been made to the State Department of Public Welfare as to the ability of the State to increase its allocations for General Relief and Old Age Assistance.

"Whether the State will be able to liberalize its present policy will depend upon future legislative enactment.

"The total expenditure for public assistance in Ohio during 1949 (at both the state and local levels) amounted to approximately $112.8 million. During 1948, this amount was $96.5 million; and in 1947, $82.2 million.

INCREASES SHOWN

"In 1949, the unduplicated average monthly 'case load' was 169,331, involving 271,002 persons; as compared with 156,998 cases, involving 228,546 persons in 1948; and 151,108 cases, involving 208,843 persons in 1947.

"It should be noted that the expenditures for public assistance in Ohio in 1949 were over $30 million more than in 1947.

"The foregoing figures cover all forms of public assistance, and include administrative costs. As this discussion will be limited to General Relief and Aid for the Aged, no further reference will be made to the Aid to Dependent Children and Aid to the Blind programs in Ohio.

NO U. S. HELP

"Under our laws, the Federal Government does not participate in any way in Ohio's General Relief Program which is administered by local

TABLE NO. 1

EXPENDITURES FOR GENERAL RELIEF, BY SOURCE OF FUNDS

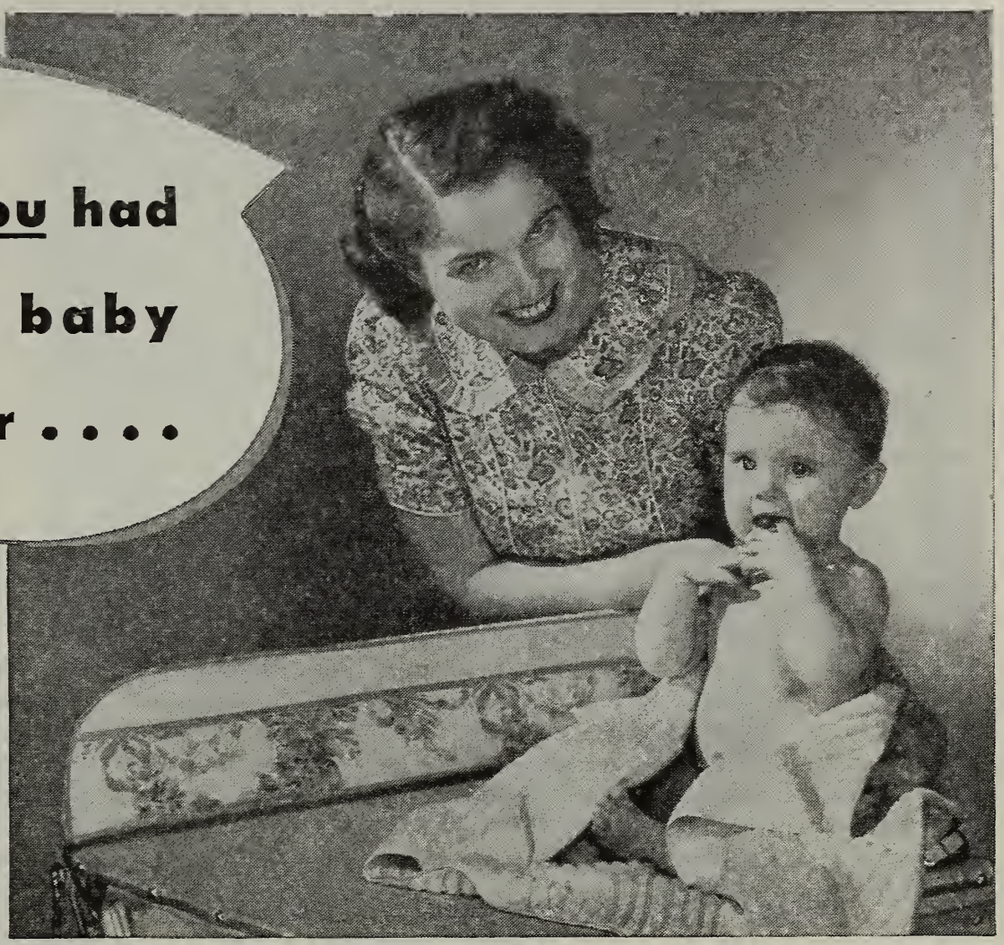
	Total Expenditures	*State Funds*	*Local Funds*	*State Percentage*	*Local Percentage*
1949	$24,957,000	$22,597,000	$2,360,000	90.5	9.5
1948	17,847,000	17,531,000	316,000	98.2	1.8
1947	12,118,000	12,116,000	2,000	99.95+	.05—

In the above table, public utility excise taxes collected by the State and distributed to local relief areas on a formula basis, together with the legislative appropriation from the State's General Revenue Fund are designated as "State" funds. The amounts from these sources distributed in each of the years 1947, 1948, and 1949 is shown below. In 1948 and 1949, when State's funds used exceeded the distributions within the respective years, the difference was provided from balances of utility excise taxes remaining unexpended from previous years in local treasuries.

STATE FUNDS DISTRIBUTED FOR GENERAL RELIEF, BY SOURCE

	Total	*Legislative Appropriation from State's General Revenue Fund*	*Public Utility Excise Taxes*
1949	$20,062,000	$10,971,000	$9,091,000
1948	16,303,000	8,878,000	7,425,000
1947	12,786,000	6,013,000	6,773,000

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3. Two added sugars—lactose and dextrose.
4. Full requirements of Vitamins A and B_1.
5. Not less than 800 units of Vitamin D per quart.
6. Added iron.
7. Zero curd tension.

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Very truly yours,

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ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

TABLE NO. 2

AID FOR THE AGED

	Total Expenditures	State Funds	Federal Funds	State Per cent	Federal Per cent	No. of Recipients at End of Year	Average Grant for December
1942	$43,145,000	$21,693,000	$21,452,000	50.3	49.7	138,402	$26.97
1947	60,336,000	28,075,000	32,261,000	46.5	53.5	123,001	40.31
1948	66,997,000	31,628,000	35,349,000	47.2	52.8	124,223	46.45
1949	74,477,000	33,075,000	41,402,000	44.4	55.6	127,095	46.77

relief areas, under standards prescribed by the State.

"Ohio laws contemplate that expenses for General Relief shall be shared by both the state and local governmental units. Funds to meet the expenditures of this program come from appropriations made by the Legislature from the General Revenue Fund, from state-collected public utility excise taxes and by appropriations made by local governmental units. During the past several years, however, nearly all of the funds for this program have been provided by the State as shown in table No. 1.

"As the State distributed over $7 million more to local relief areas for general relief in 1949 than it did in 1947, and in view of the present condition of the State Treasury and the other requirements of the State government, it is improbable that the State will be able to enlarge its grants for General Relief to any great extent in the future without the imposition of new taxes.

FIGURES ON AID FOR THE AGED

"In January, 1942, the number of recipients on the Aid for the Aged assistance rolls reached a peak of 139,567 persons. During 1942, the total expenditures in the Aid for the Aged program were $43.1 million, and at the end of the year the average grant was $26.97.

"At the inception of the Aid for the Aged program in Ohio in 1934, all of the funds were provided by the State. The average grant during the first month of operation was $12.74. In August, 1936, the Federal government made Federal funds available for matching and this has continued ever since.

COSTS GO UP

"While there was a downward trend in the number of recipients from January, 1942, until early in 1946, the cost of maintaining this program has continued to increase, with the exception of the years 1944 and 1945, until 1949, when a total of $74.5 million was expended under the Aid for the Aged law. On December 31, 1949, there were 127,095 persons receiving aid for the aged assistance and the average grant was $46.77.

"The table above (table No. 2) shows the trend in the cost of operating the Aid for the Aged program in Ohio, and the source of revenue to maintain the program.

"Practically all of the amendments to the Aid for the Aged law since its original enactment have had a tendency either to increase the maximum grant or to broaden the scope of the law, making a large number of persons eligible for assistance.

STATE PAYING MORE

"The State's share for operating the old age assistance program is now $5 million more per year than it was in 1947. The present standards of assistance should not be lowered if it can be avoided. Since the number of people over 65 years of age is rapidly increasing, and the capacity of public support being limited, it is very apparent that each application must be carefully scrutinized to see that all grants are made on the basis of actual need, that the same rules are uniformly applied all over the State, and that no one will be placed on the rolls who has adequate resources or responsible relatives available for full support.

"In the face of a prospective declining economy, it will be difficult for the State to maintain its present standards of assistance in the future under present tax laws, unless the average grant and the number of recipients can be kept at its present level."

New V. A. Ruling On T. B.

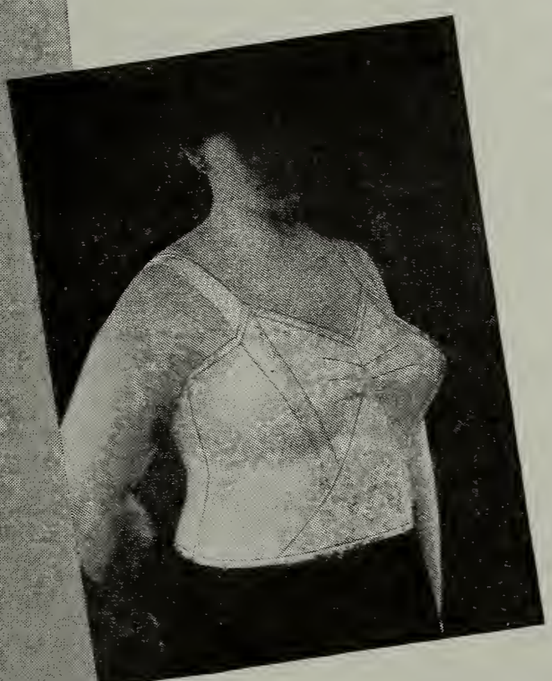
Veterans of World War II who develop pulmonary tuberculosis within three years of date of discharge are granted new presumptions of service-connection for purposes of compensation, hospitalization and medical treatment under the terms of Public Law 573, approved by the President June 23. Previous law provided a presumptive period of one year. The extension is designed to match the period allowed veterans following World War I.

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CORDELIA "CONTROL-LIFT" Brassieres provide over 600 custom fittings, with trained personnel in better stores and surgical supply houses everywhere, fully qualified to scientifically measure-and-fit even the most unusual cases.



CORDELIA "CONTROL-LIFT" Brassieres feature inner-cup construction for added support; extra-wide, continuous straps for utmost comfort; no over-shoulder cutting for the pendulous-type bust. Sizes range as high as 56.

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Impact of War on Physicians . . .

Need for Additional Doctors in Armed Services Analyzed; Plans Under Way To Obtain Required Number; Other Data On Aspects of Preparedness

WHAT effect will the war in Korea and expansion of the armed forces have on the medical profession?

It is hazardous to make predictions—in fact to even present factual material —as the situation is changing so rapidly—almost daily.

However, the following points can be set forth with some degree of certainty, although the reader should keep in mind that over-night developments can change them materially:

1. There will be big increases in the size of all branches of the armed services. This will mean comparable expansion of the personnel of the medical corps of the three services. Plans which are being considered to accomplish this will be discussed in this article.

2. Creation of Civilian Defense Programs for the protection of the civilian population in event of enemy attack or disasters affecting the preparedness program will require the use of medical manpower for planning and operational activities. (See special article on Civilian Defense, page 926.)

3. Stepping up of the blood procurement program of the American Red Cross, which has been designed by the Secretary of Defense to procure blood and its derivatives needed by the armed forces, will require the assistance and cooperation of additional physicians.

4. Selective Service will need additional physicians under its greatly accelerated program.

5. County Medical Societies will be called upon time and again to name representatives to advise and assist various agencies playing some part in local activities related to the national emergency and the preparedness program.

HUNDREDS NEEDED

Barring a complete agreement with Russia, it is no secret that **Army, Navy and Air Force will need hundreds—perhaps thousands—of additional medical officers in the very near future.**

Currently doctors of medicine in the three services total 6,000, including men in training and serving internships and residencies. Medical Reserve rolls total around 30,000 men.

The three services now have **about run out of any marginal medical manpower.** Top military medical officers are reluctant to order individual reserves into service ahead of military-age men who have not served. **But it is their responsibility to meet medical demands of their services—and they have full authority to order any and all reserves to duty.**

CALL OF ARMY RESERVES

The Army has announced that it will call to active duty 734 medical reserve officers by October 1. Ohio's quota is 38 physicians. The quota for the Second Army area, which includes Ohio, Pennsylvania, Maryland, Virginia, West Virginia, Delaware and Kentucky is 141.

In making selections, Army commanders have been ordered to "make every effort" to enlist the cooperation of established medical societies.

All officers selected will be ordered to the nearest Army post for physical examinations. If found physically fit, they will be given 21 days to wind up their private affairs unless they are willing to report sooner, Army announced.

It is anticipated that one-third of the group will report by September 22 and another third by September 29.

The Army announced that deferment from involuntary call will be granted to reserve medical officers in the following five categories:

1. Those who have not completed a year's internship.

2. Those who are senior residents, prior to completion of the current year's training.

3. Reserve officers taking full-time postgraduate courses, until completion of the current academic year.

4. Reserve officers whose activity in teaching, research or other activities is necessary to the national interest.

5. Those doctors whose call would unduly

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jeopardize the health of communities in which they live.

The Army further announced that it will continue to accept voluntary applications for active duty from medical officers. Officers so obtained will be credited against the State's quota. Officers who volunteer will receive an extra $100 per month.

Application forms for voluntary service may be obtained through the Chief of the Ohio Military District, Fort Hayes, Columbus.

INTERNS STAYING IN

Over 75 per cent of the medical graduates who interned in Army hospitals under the Military Intern Training Program have remained in the Army longer than their legal requirement for active duty, according to figures released by Major General R. W. Bliss, the Army Surgeon General.

Of the 311 young physicians who have passed through the program, 235 have elected to remain on active duty in the Army Medical Service, either as Regular or Reserve officers. Of the other 76, several have requested return to active duty after a comparatively brief period of nonmilitary practice. All but seven of the 76 retained their Reserve Commissions.

ABOUT V-12, A. S. T. P. DOCTORS

The question of whether compulsion will have to be used to bring the medical corps of the three services up to adequate strength will probably be settled shortly. So far pressure has been brought to bear on certain groups of physicians to volunteer for duty. They are: (1) Former Navy V-12 and Army A. S. T. P. medical students who were deferred from active duty during World War II and who had all or part of their medical education paid for by the government; (2) men who were deferred from active service during the war to complete their medical education at their own expense; (3) physicians who were assigned to residencies and internships on active duty status who were allowed to leave the service upon completion of training.

Few of these classes of physicians, numbering 8000-9000, have volunteered. Even the question of compelling them to serve at this time is a moot one. Apparently the government has no legal hold on most—if not all—of them. Repeated appeals from the three services for medical volunteers during the month of July brought a total of 68 doctors to active duty. Totals by services were Army 22, Navy 40 and Air Force six.

DRAFT LEGISLATION PROPOSED

However, early hearings are expected in Washington on two proposals presented to the Congress which are designed to provide for the drafting of physicians falling in the above classifications.

Both H. R. 9311 (Representative John Saylor, R.-Pa.) and H. R. 9294 (Representative Anthony Cavalcante, D.-Pa.) provide for Selective Service registration of all persons with "**needed professional, technical and specialist**" skills who are not yet 45 years of age. Inductions, however, would not exceed twenty-one months in the armed forces. In making calls for such persons the President would induct in the following order of priority: 1. Those who participated as students in the A. S. T. P. or similar programs administered by the Navy and persons deferred from service during World War II for the purpose of pursuing their education in the same scientific categories covered by such programs and who have had no active duty as commissioned officers; 2. Those who have participated in such programs and who have served on active duty as commissioned officers for less than twenty-one months; 3. Those who have less than ninety days' prior active honorable military duty; 4. Those whose total active honorable military duty is less than twenty-one months; 5. Others prescribed by the President.

Mr. Saylor followed up with another bill (H. R. 9327), this one aimed specifically at A. S. T. P. and V-12 educated **physicians and dentists**, and making no reference to non-medical skills. Mr. Saylor is confident this bill will not be ruled out as discriminatory or class legislation, a consideration responsible for inclusion of the other skilled categories in earlier bills. Men inducted under this bill would be assured the rank of first lieutenant, and **would be required to remain in reserves at least six years** after going off active duty.

A. M. A. APPROVES

The Council on National Emergency Medical Service of the American Medical Association at a recent meeting in Washington expressed its support of legislation, if necessary, to provide for the military call on a priority schedule of physicians needed for national defense.

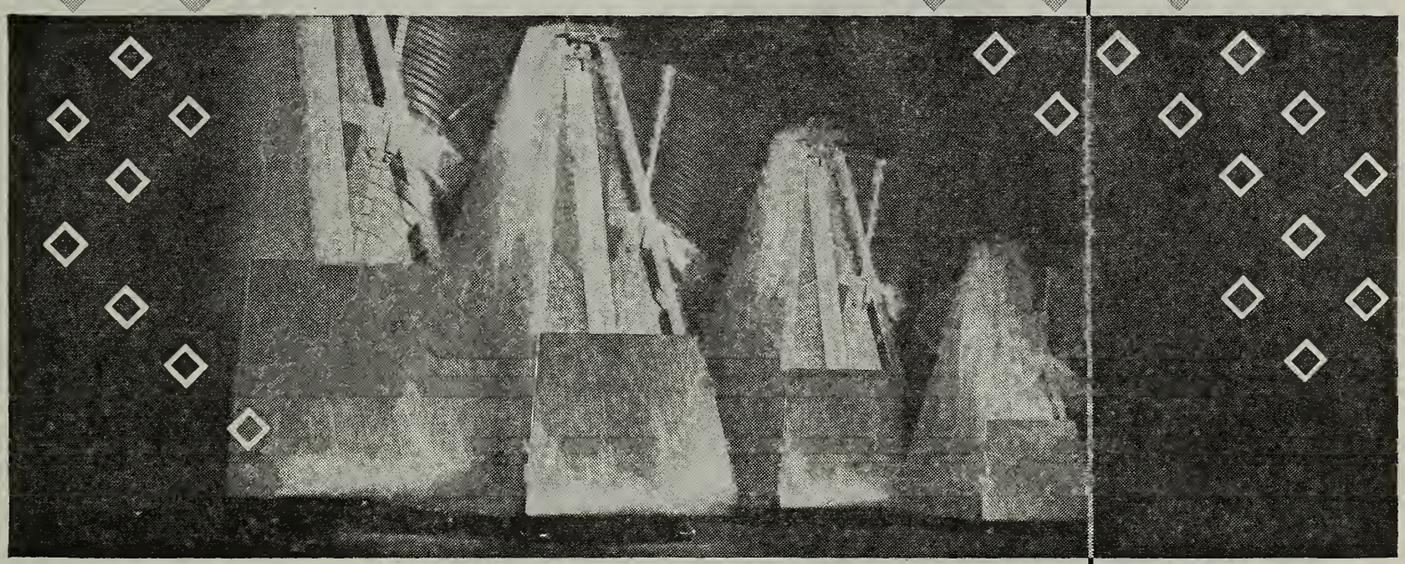
The council's recommendation, submitted to the A. M. A. Board of Trustees for approval, placed emphasis on the first call of the non-veteran physicians who received training at government expense during and since World War II and of all others who were deferred in order to complete their medical studies.

The recommendation was based on the understanding that an appropriate body be established in government to effect certain measures relative to the utilization of physicians by the medical departments of the Armed Forces.

BOARD OFFERS RECOMMENDATIONS

The Board of Trustees of the A. M. A. after considering the recommendations of the Council

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on National Emergency Medical Service, voted its definite endorsement of the principles of the several bills pending in Congress which provide for the registration and induction into service of physicians.

Dr. Louis H. Bauer, chairman of the Board, in announcing the Board's action, said that any legislation enacted should provide for a call in the following order:

1. Former students in A. S. T. P. or V-12 programs and persons deferred during World War II in order to continue their medical education and who have had no active duty.

2. Those deferred previously for other than physical disability and those previously rejected for physical disability who may be found fit on the basis of present physical requirements.

3. Former students in A. S. T. P. or V-12 programs who served on active duty as commissioned officers for less than 21 months, exclusive of time in postgraduate training.

4. Those who served less than 90 days on active honorable military or naval duty.

5. Those whose total active honorable military or naval duty is less than 21 months.

STUDENTS MAY BE DEFERRED

Under the Selective Service Law, medical students **may not be called away from their studies and inducted** as long as their scholastic records are satisfactory. Authority for this is Sec. II-A of the law's industrial deferment section. Decision as to whether the student's progress is satisfactory is left entirely to the discretion of the local draft board, which also is guided by the general statement that the deferment must promise to contribute to the nation's health.

MEDICINE RATED "ESSENTIAL"

Further tightening the military medical situation is a **Department of Labor** list which includes doctors among those whose services are essential to the civilian economy. The list was issued as a guide to military services in considering deferment of reserve officers, and was accepted by Department of Defense. **This is purely advisory, and the services remain the final judge of what reserve officers to call up.** However, it is an official reminder that the civilian practice of medicine should be given adequate consideration. The list also includes bacteriologists, biologists, botanists, chemists, dentists, nurses, osteopaths, parasitologists, pharmacognists, pharmacologists, physicists, plant pathologists, veterinarians and teachers in the critical occupations. Under this policy, deferments would be for not more than six months, and deferment could not be extended beyond an additional six months. Requests for deferment should not be made prior to receipt of mobilization orders, and in every case the military service reserves the right to cancel deferment for "overriding military considerations."

NATIONAL ADVISORY COMMITTEE

Realizing that problems of health resources are basic in mobilization for defense, Chairman W. Stuart Symington of the National Security Resources Board is setting up a health resources advisory committee. He has named as chairman of the committee, Dr. Howard A. Rusk, chief of physical medicine and rehabilitation at New York University-Bellevue Medical Center. Other members have not been named.

Rusk's committee will have much to say regarding policies on mobilizing medical manpower, utilization of hospital facilities and coordination with the public health services.

REGARDING NURSES

Navy already has started issuing mandatory orders to a few reserve **nurses**, but declines to state the exact number. **Army** and **Air Force**, however, so far have issued no mandatory orders, and expect they may be able to meet all requirements through volunteers. Although **Army** needs 750 nurses in the next few months, it is receiving about 15 inquiries a day and says that half of these ask for active duty assignments. **Air Force**, in need of about 600 nurses, also anticipates that volunteers will solve the problem. The **Army** is not doing so well in active duty volunteers for its Women's Medical Specialists' Corps; it has immediate need for 70 dietitians, 40 physical therapists and 65 occupational therapists.

In its **nurses**, Navy has a problem not shared by the other services. Although 5,000 nurses are still in the Naval reserve, most of them have not kept up contact with the service offices. Navy officials are anxious to have them report on their present status. If they are married, and have a child or children under 18 years of age, they will be removed from the eligible list.

WANT U. S. MEDICAL SCHOOL

While the armed services were stepping up appeals for physicians, two Democratic Representatives revived the proposal for a **U. S. Academy of Medicine**, which would insure a steady flow of doctors to Army, Navy and Air Force.

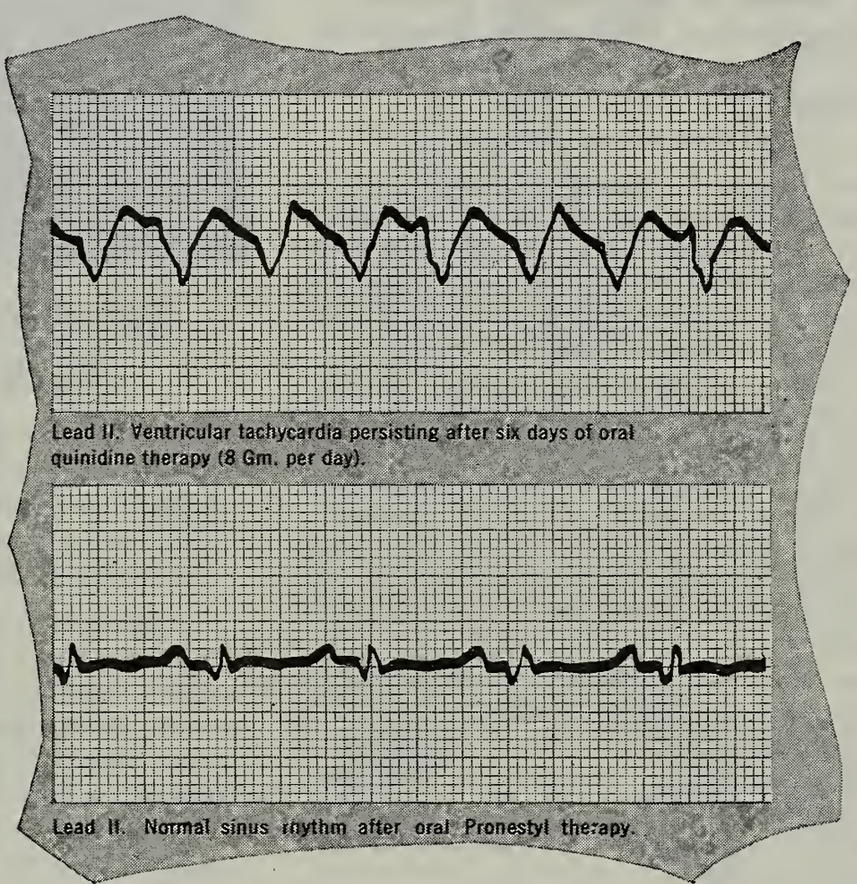
Representative Anthony Cavalcante (Pa.) proposes that a Federal medical academy be established in or near Washington. Appointments would be made somewhat in the way appointments now are made to the military academies at West Point and Annapolis—150 to be nominated by the President, 10 by the Vice-President and the remainder by Representatives and Senators. Enrolment would be limited to 2,304, and no more than 500 could be appointed any one year. After finishing the Academy's

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Squibb Procaine Amide Hydrochloride



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course, men would serve internships in military hospitals, then be **obligated for six years' service with Army, Navy or Air Force**, as reserves on active duty. Also, these physicians might be assigned to V. A. hospitals, or discharged from active duty if their services were not required. They would not have the option of resigning from the reserves, but would be kept subject to call until their retirement.

The bill (H. R. 9157) by Representative Louis Heller (N. Y.) differs from Mr. Cavalcante's (H. R. 9156) in many respects. **It would permit assignment of academy graduates to any Federal service, military or non-military.** Proposals of this nature received considerable attention immediately after the war, but no action was taken by Congress.

RED CROSS BLOOD PROGRAM

General George C. Marshall, president of the American Red Cross, has accepted a request by Secretary of Defense Louis Johnson that the Red Cross become the official agency for the procurement of blood for the armed forces when such blood and its derivatives are needed.

In his letter of acceptance General Marshall assured Secretary Johnson the Red Cross was prepared at once "to increase the output of its national blood program to provide the armed services with the blood that may be required."

Secretary Johnson recalled in his letter that the blood procurement task performed by the Red Cross during World War II "was most successful."

General Marshall designated Vice-Admiral Ross T. McIntire, (M. C.) USN, Retired, of the Red Cross National Blood Program, to work with Dr. Richard L. Meiling, (formerly of Columbus, Ohio) director of Medical Services of the Department of Defense, to coordinate and develop the plan.

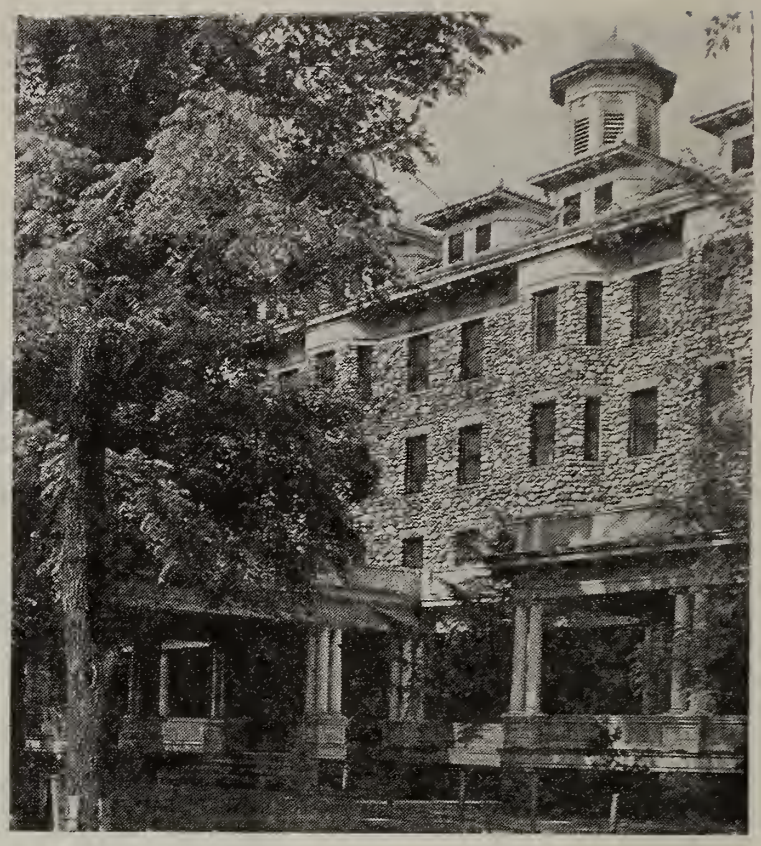
At present 34 regional blood centers and 46 mobile units are operating in the Red Cross blood program. They are now collecting approximately 63,200 pints of blood a month for civilian use. A total of 677 Red Cross chapters are participating in the collection and processing centers. The regional centers are serving more than 1,900 hospitals in 38 states.

COLUMBUS A CENTER

One of the regional centers is at Columbus, Ohio, which serves the Central Ohio Area, consisting of 23 counties and including 27 Red Cross Chapters. That center already has felt the impact of General Marshall's acceptance of Secretary Johnson's request.

Although no quotas for blood for military use have as yet been received by the Columbus Center it is planning to step up its activities many fold to meet demands which will come later.

The Columbus center is under the supervision



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Battle Creek Sanitarium has been offering its outstanding services continuously for 85 years; John Harvey Kellogg, M.D., served as its superintendent from 1876 to 1943.

Wire or call collect for complete information on availability of accommodations.

THE BATTLE CREEK SANITARIUM
BATTLE CREEK, MICHIGAN

of Dr. Charles A. Doan, dean of the Ohio State University College of Medicine and a member of a five-physician medical advisory committee to the National Red Cross Blood Program.

COUNTIES IN AREA

Counties covered by the Columbus Center are: Ashland, Athens, Champaign, Coshocton, Crawford, Delaware, Fairfield, Fayette, Franklin, Hardin, Hocking, Knox, Licking, Logan, Madison, Marion, Miami, Perry, Pickaway, Richland, Ross, Shelby and Union.

There is a possibility that the Red Cross blood procurement program may be expanded to other parts of Ohio to operate independently or in cooperation with existing blood procurement and blood bank programs. No definite plans have been made for this as yet.

Immediate increase in the number of donors throughout the Central Ohio area is imperative, according to Dr. Doan.

So far, there has not been enough blood collected to meet the needs of all the hospitals, let alone having any to make a substantial stockpile of plasma or other blood derivatives.

MEDICAL ADVISORY COMMITTEES

As the Red Cross Blood program operates under the direct supervision of the medical advisory committee of each chapter, more responsibility than ever will be placed on the physicians appointed to the local medical advisory committees.

At a meeting of physicians on advisory committees and public health and hospital personnel held in Columbus July 27, plans were formulated for organizing a regional medical advisory committee. This will be elected by the representatives of the local medical advisory committees when they meet again in Columbus on October 26.

International Surgeons' Assembly Headed by Dr. Curtis

The International College of Surgeons, United States Chapter, will hold its 15th Annual Assembly and Convocation in Cleveland, October 31-November 3, according to Dr. George M. Curtis, Columbus, chairman of the Assembly.

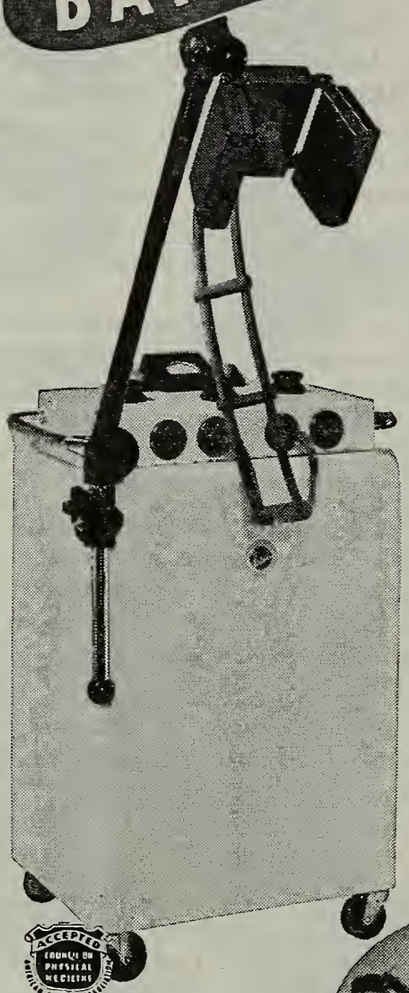
The program will include scientific sessions on subjects in the fields of general surgery; eye, ear, nose and throat surgery; gynecology and obstetrics; urology; and orthopedic, thoracic, plastic and neurological surgery. In addition, an extensive exhibit and special entertainment will form part of the Assembly.

All doctors of medicine interested in surgery and its advancement are invited to attend. A program may be obtained from Dr. Arnold S. Jackson, secretary, Jackson Clinic, Madison 4, Wisc. For hotel reservations, contact Committee on Hotels, International College of Surgeons, U. S. Chapter, 511 Terminal Bldg., Cleveland 13.

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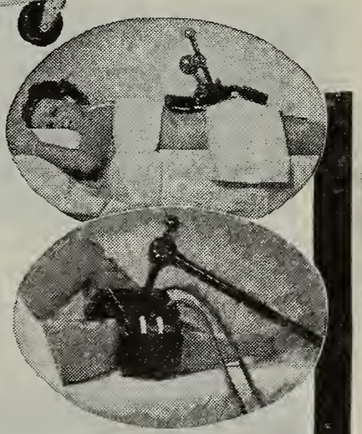
✓ Federal Communications Commission

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Medical Care Price Indexes Below Cost of Living for 1949

Indexes of medical care prices were not as high as the general cost of living during 1949, according to a study made by Frank G. Dickinson, Ph. D., Chicago, director of the American Medical Association's Bureau of Medical Economic Research.

The Consumers' Price Index of the United States Bureau of Labor Statistics measures changes since 1935-1939 in prices of fixed quantities of goods and services normally purchased by moderate income families in large cities.

"The relative importance of the medical care items among all the items in the Consumers' Price Index is slightly more than 3 per cent," Dr. Dickinson points out.

"Thus, the index of the price of medical care may be considered a small but significant part of the Consumers' Price Index. With the exception of drugs, the index for physicians' services rose least of all medical care items between 1948 and 1949." '

The 1949 index for physicians' fees was 137.9. In 1948 it was 135.5. The 1949 index for general practitioners' fees was 137.7, which may be compared with 135.2 in 1948. The 1949 index for surgeons' and specialists' fees was 138.4, compared with 135.8 in 1948.

"This relatively small increase in the index for physicians' services strongly suggests that the demand for physicians' services in relation to the supply was not excessive," Dr. Dickinson says.

"The index for hospital room rates, again the highest of all the medical price indexes, was 226.8 in 1949, or 17.1 points higher than the 1948 index. The hospital, a buyer of large quantities of goods and services—labor, food, fuel—which have undergone great increases in price, is fully subject to the forces of inflation. On the average, however, patients stay in the hospital fewer days.

"The price indexes for other medical care items in 1949 were considerably lower than the Consumers' Price Index. The index for medical care excluding drugs was 149.7 (144.4 in 1948); the index for drugs alone was 123.3. The index for dentists' fees was 150.6.

"To the extent that these indexes reflect nationwide trends, in 1949 Americans were again fortunate in that the prices of medical care had not risen as rapidly as the general cost of living since 1935-1939."

New Arthritis Film

The Arthritis & Rheumatism Foundation has announced the production of a new color, sound-on-film feature reviewing the incidence and economic and social significance of arthritis and rheumatism.

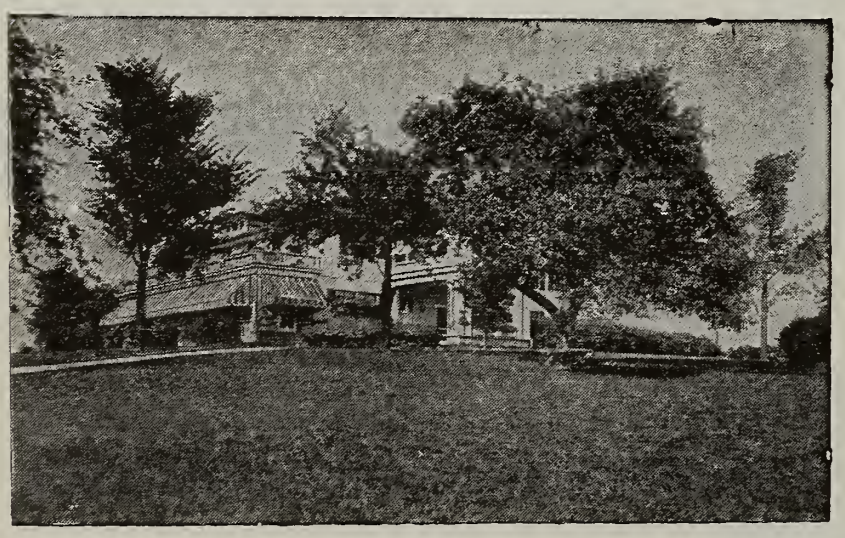
The new film stresses the fundamental importance and limitations of hormone therapy in treating these chronic diseases, using case histories of cortisone and ACTH treatments.

Production schedule calls for the film to be ready about September 1. Prints are obtainable for showing by county medical societies and other groups. Address the American Rheumatic Association, Dr. Charles Ragen, Secretary, Presbyterian Hospital, New York 32, New York. Only charges are to cover shipping.

Activities of The Editor

Dr. Jonathan Forman, Editor of *The Journal*, has assumed editorship of a bibliographical section of the *Quarterly of Allergy and Applied Immunology*. This is a transfer to this magazine of a service which Dr. Forman has been providing for *Letters of the International Correspondence Society of Allergists* for the past five years.

An estimated 66,000 eye injuries—750 of them so serious that the child loses the sight of an eye—occur during each school year among American children, the National Society for the Prevention of Blindness revealed.



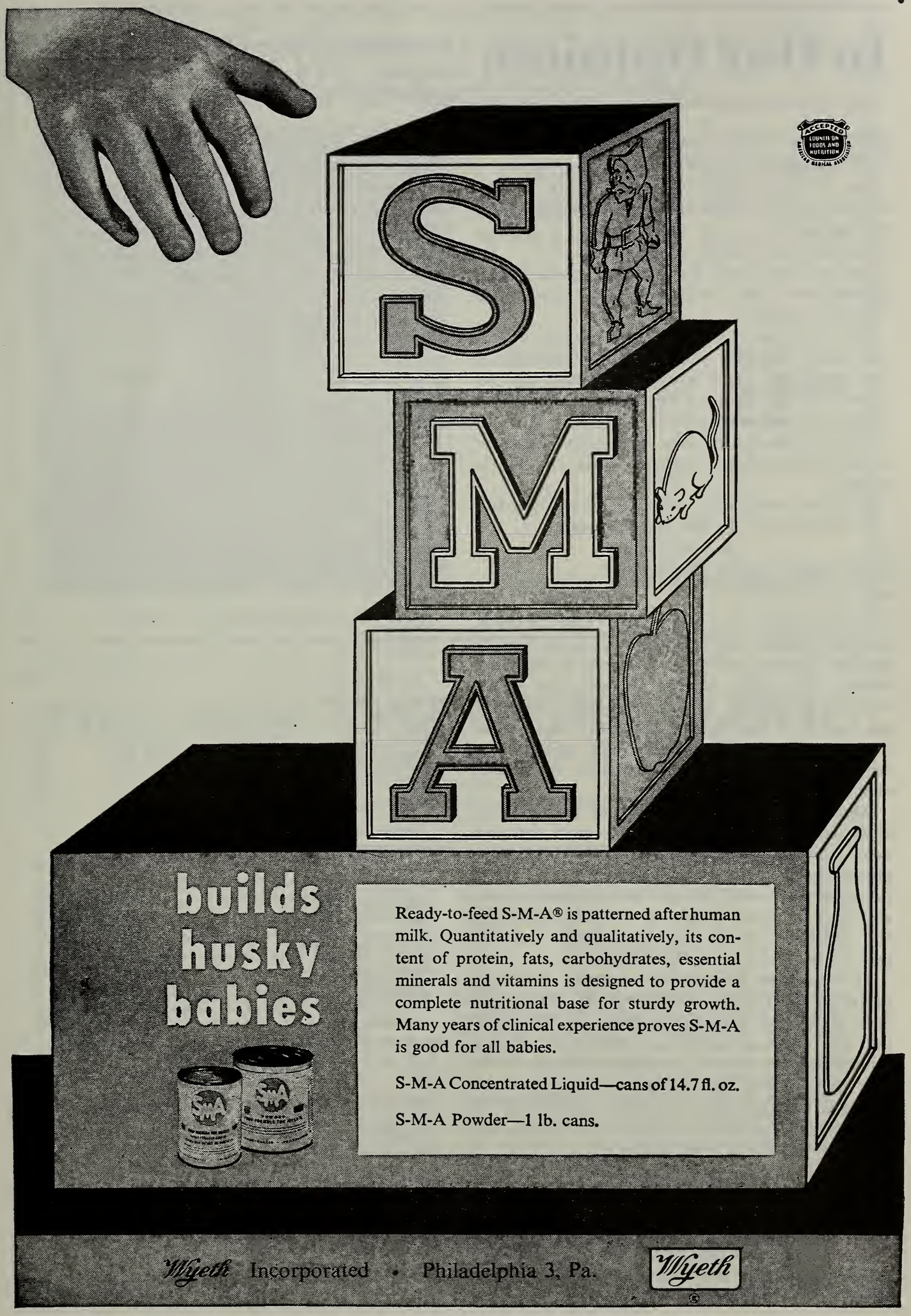
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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

YOUR ONE VOTE MAY BE THE DECIDING VOTE

So you don't think it matters much whether or not your **one vote** is cast on Election Day—November 7?

History says you're wrong.

Do you know that Jefferson and John Quincy Adams were each elected by **one vote** in the Electoral College?

Do you know that Hayes was elected by **one vote**; his election contested, and upheld by **one** vote; the Congressman who cast the deciding vote in favor of Hayes was elected by a margin of **one vote?**

Do you know that **one vote** gave statehood to California, Idaho, Oregon, Texas and Washington?

No doubt many other examples could be cited.

Your vote may be the deciding vote.

LAST CALL FOR PAYMENT OF A. M. A. DUES

If you have not paid your 1950 A. M. A. dues of $25.00, the Secretary of your County Medical Society will be seeing you in the near future. On order of The Council, the Secretary of each local society has been furnished the names of members of the State Association who have not paid A. M. A. dues and he has been requested to get in touch with the unpaid members.

Approximately 5,225 members of the O.S.M.A. have paid A. M. A. dues. That's good, but not good enough. Surely, there is not a single physician who won't admit that the A. M. A. is carrying on many, many excellent activities—activities of great benefit to the profession and the public—even if he may disagree with a few of the policies of the A. M. A.

The A. M. A. must have adequate funds to carry on its regular work and programs. Its only source of revenue is from its members. Can you think of a single organization of any consequence to which a person belongs which does not expect its members to make some financial contribution? It's time for all of us to rationalize on this question. Let's not fail to see the woods for the trees.

Physicians who don't pay A. M. A. dues by the end of the year will be taken off the membership roster of the A. M. A. in compliance with the By-Laws. To have his name restored to membership at some future date, a physician will have to pay 1950 dues, and dues for any other year in which he is delinquent, in addition to the current dues. A. M. A. dues for physicians becoming members of their local medical society and the State Association after July 1 are on a pro-rata basis of $12.50.

If you are interested in knowing how your County Medical Society stacks up, following is a tabulation of State Association members by counties and the number of such members who had paid A. M. A. dues at the time this issue of *The Journal* went to press:

COMPARISON OF O. S. M. A. MEMBERSHIP AND A. M. A. DUES PAID

	O.S.M.A. Membership	A. M. A. Dues
FIRST DISTRICT:		
Adams	8	6
Brown	8	4
Butler	123	73
Clermont	26	17
Clinton	18	9
Hamilton	959	690
Highland	20	12
Warren	16	11
Totals	1178	822
SECOND DISTRICT:		
Champaign	19	13
Clark	115	77
Darke	26	17
Greene	37	24
Miami	45	39
Montgomery	370	253
Preble	13	8
Shelby	19	16
Totals	644	447
THIRD DISTRICT:		
Allen	89	69
Auglaize	18	11
Crawford	32	21
Hancock	37	24
Hardin	26	16
Logan	23	18
Marion	46	29
Mercer	15	13
Seneca	42	32
Van Wert	19	16
Wyandot	14	10
Totals	361	259
FOURTH DISTRICT:		
Defiance	16	11
Fulton	19	15
Henry	11	3
Lucas	445	325
Ottawa	17	11
Paulding	9	4
Putnam	15	8
Sandusky	45	35
Williams	17	10
Wood	33	28
Totals	627	450
FIFTH DISTRICT:		
Ashtabula	52	30
Cuyahoga	1622	1217
Geauga	12	9
Lake	39	29
Totals	1725	1285

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A three months combined full time refresher course consisting of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; clinical and cadaver demonstrations in bronchoscopy, laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology, bacteriology and embryology; physiology; neuro-anatomy; anesthesia; physical medicine; allergy; examination of patients pre-operatively and follow-up post-operative in the wards and clinics.

PROCTOLOGY AND GASTROENTEROLOGY

A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; witnessing operations; ward rounds; demonstration of cases; pathology; radiology; anatomy; operative proctology on the cadaver.

DERMATOLOGY AND SYPHILOLOGY

A three year course, beginning in October, fulfilling all the requirements of the American Board of Dermatology and Syphilology.

RADIOLOGY

A comprehensive review of the physics and higher mathematics involved, film interpretation, all standard general roentgen diagnostic procedures, methods of application and doses of radiation therapy, both X-ray and radium, standard and special fluoroscopic procedures. A review of dermatological lesions and tumors susceptible to roentgen therapy is given, together with methods and dosage calculation of treatments. Special attention is given to the newer diagnostic methods associated with the employment of contrast media such as bronchography with Lipiodol, uterosalpingography, visualization of cardiac chambers, pre-renal insufflation and myelography. Discussions covering roentgen departmental management are also included.

For Information Address

345 WEST 50th STREET **MEDICAL EXECUTIVE OFFICER** NEW YORK CITY 19

	O.S.M.A. Membership	A. M. A. Dues
SIXTH DISTRICT:		
Columbiana	66	57
Mahoning	233	170
Portage	31	23
Stark	267	202
Summit	345	254
Trumbull	97	63
Totals	1039	769
SEVENTH DISTRICT:		
Belmont	51	35
Carroll	9	9
Coshocton	23	15
Harrison	10	6
Jefferson	58	38
Monroe	4	2
Tuscarawas	51	29
Totals	206	134
EIGHTH DISTRICT:		
Athens	30	20
Fairfield	45	24
Guernsey	28	18
Licking	57	38
Morgan	7	4
Muskingum	52	38
Noble	3	2
Perry	13	5
Washington	28	16
Totals	263	165
NINTH DISTRICT:		
Gallia	19	11
Hocking	11	4
Jackson	14	6
Lawrence	23	14
Meigs	11	6
Pike	9	2
Scioto	69	43
Vinton	3	3
Totals	159	89
TENTH DISTRICT:		
Delaware	20	14
Fayette	10	8
Franklin	657	461
Knox	31	28
Madison	13	8
Morrow	8	7
Pickaway	15	7
Ross	43	33
Union	13	7
Totals	810	573
ELEVENTH DISTRICT:		
Ashland	26	16
Erie	49	28
Holmes	9	7
Huron	24	18
Lorain	120	83
Medina	29	23
Richland	95	80
Wayne	51	27
Totals	403	282
Total O. S. M. A. Membership, Aug. 9, 1950		7,415
Total A. M. A. Dues Paid, Aug. 9, 1950		5,275

ESSENTIAL ROLE OF PHYSICIANS IN HELPING THE HANDICAPPED

Committees are being organized in many Ohio communities to promote "Employ the Physically Handicapped Week" which will be observed on a national basis the week of October 1-7. During the week employers will be urged to re-examine their attitudes toward the hiring of qualified handicapped workers.

Literature, based on competent surveys, reveals that the work records of the handicapped have shown that they are equal or better than many non-handicapped workers in the following aspects of job performance, if they are properly placed: Their rate of absenteeism is lower; they are not "job hoppers"; their rate of production is high; their accident rate is low.

This program is designed especially to inform and stimulate the interest of employers. So far as the practicing physician is concerned every week should be employ the physically handicapped week.

In the first place, physicians are essential in programs of rehabilitation which are going on 365 days a year in many areas.

Secondly, the physician can play a major role in aiding the handicapped to secure satisfactory employment. In submitting reports on the degree of handicap of an injured worker, the physician should emphasize the positive. Namely, he should emphasize what the handicapped person is capable of doing—not necessarily that which he cannot do. In other words, the physician should go out of his way to cooperate with the patient and employers in trying to find the proper job for the disabled person—a spot where he can render efficient service despite his handicap.

Physicians should give their support to the programs planned for the week of October 1-7. However, they should do more than that. They should make this a year-round project so far as their own handicapped patients are concerned. When the physican gives them good care, boosts their morale, and aids in getting them back into productive employment, he renders a real service to everyone—the disabled, the employers and the community at large.

RURAL PRECEPTORSHIPS PROGRAM STUDIED

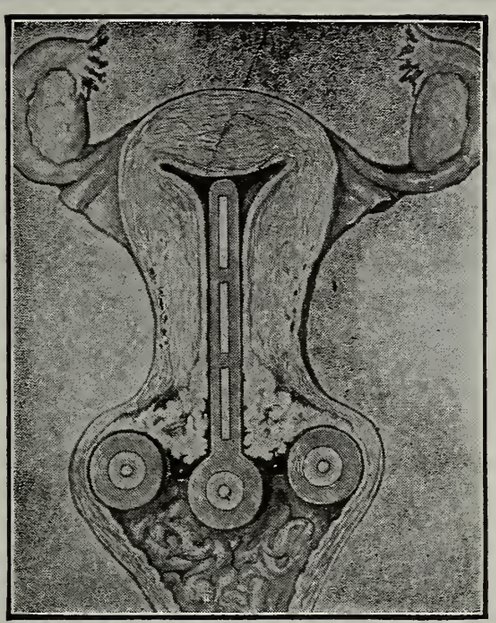
Pick up a copy of the August 15 issue of *Look* magazine and read the article beginning on page 37.

Entitled "How Kansas Finds Country Doctors," the picture story follows one of 39 extern students of the University of Kansas School of Medicine through a day or two of his affiliation with a country doctor preceptor.

Kansas calls it a "field training" program. Already in operation in two other states, first in Wisconsin, later in Oklahoma, the rural preceptorship program is designed to encourage young physicians to settle in rural areas by sending them for a time to the "front lines" with a general practitioner during the interim between the junior and senior years of medical school.

The Committee on Rural Health of the Ohio

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ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION



State Medical Association has been studying a large quantity of detailed information procured from all three states, preparatory to deciding whether to recommend to the Council of the Association that such a plan be introduced in Ohio.

More than a year ago, in connection with this study, a questionnaire survey of a representative group of Ohio general practitioners located in towns of 2500 or less population showed that the majority of those replying were willing to cooperate in such a program.

This, we think, is important, for such a plan involves an additional burden for the physician . . . time must be taken to instruct the student while patients are being treated. Too, the student must be housed and fed.

These physicians are to be congratulated on their willingness to make these sacrifices in order to help make possible the continuation of the heritage of the country doctor.

On the other hand, doctors in the states where the plan is in operation report that the preceptorship is a stimulating experience for the physician as well as for the student.

Much work remains to be accomplished when and if the plan is adopted here . . . medical schools must be approached, their cooperation secured, and a definite schedule of operations and responsibilities established.

The Committee will be glad to receive any comments or suggestions from members of the Ohio State Medical Association which would be of assistance in its deliberations.

IT WILL TAKE MORE THAN 100 TO DO THE JOB

During the early part of September, the Ohio State Medical Association is holding 11 important conferences in various parts of the state. These will be attended by the officers and legislative chairmen of county medical societies of the areas, the district councilor and the district member of the state legislative committee.

The purpose of these conferences is to review data regarding candidates for public office for whom voters will cast their ballots on November 7 and to work out practical methods of disseminating this information to all members of the medical profession of Ohio—and others.

Approximately 100 physicians will take part in these conferences. If they return to their homes and fail to follow through, the conferences will have been distinct failures. If they return to their county medical societies and do the job expected of them, the conferences will have been exceedingly worth while.

However, it will take more than the good work of 100 men to do the kind of job which will be necessary this year.

The November 7 General Election will be one of the most important—if not the most important—in the history of Ohio and the nation at large. Those who vote on November 7—goodness knows anyone in his right mind should do so this year, of all years—will, indirectly, be voting on many vital issues—socialized medicine, socialism generally, collectivism, etc. The public office holders of the future will decide these issues.

Therefore, the entire medical profession must be mobilized for action during the period leading up to the November 7 election. Individual physicians should take the information regarding candidates given to them by their county medical society officers and legislative committeemen and put it to use among their relatives, friends, neighbors and patients. If the information is not sent to them in one way or another, they should get in touch with these officials and demand it.

A committee of 100, or 200 or even 500, can't do the job. It can only be the sparkplug. The work has to be done by all of the physicians of Ohio.

This Fall offers the medical profession of Ohio a rare opportunity to make its influence on public affairs felt in a tangible way. If it falls down on the job and fails to work with other substantial groups to elect qualified men for various public offices, it will have no one but itself to blame for whatever unhappy results may accrue.

HAVE-NOTS VERSUS THE HAVES

Writing in the *Kansas City Medical Bulletin* on the theme, "Have-Nots Versus the Haves," Dr. Vincent F. Williams offers the following illustration of how smart folks get snarled up when they play fast and loose with fundamental principles. Dr. Williams says:

"Recently, a bunch of preachers passed a resolution which approved the principle of good medical care for all Americans, to which everyone should say, 'Amen.' Then they approved the principle that taxation should be used as a method of reducing the 'haves' to the 'have-nots' class. What stupid simpletons!

"In spreading this dangerous doctrine, they are unwittingly contravening precepts of the Bible and those of ordinary common, good horse-sense. For, together with some of the short-sighted among labor leaders, they forget that whenever temporary expediency dominates, the ultimate ruler of a land having only 'have-nots' is an absolute, central government—and this agency never tolerates autonomy of church or unions."

An Observation on the Accuracy of Digitalis Doses

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1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

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Civilian Defense Program . . .

Governor Moves To Make Organization All-Inclusive; Medicine's Part Important; County Societies Urged To Appoint Emergency Committees

PLANS for an extensive, all-inclusive civilian defense program for Ohio are rapidly taking shape, with medical and health problems being given a major portion of attention.

The civilian defense set-up is designed to handle any form of emergency within the state, with special emphasis being placed on assistance in the event of enemy action. Naturally, the part that medical and health officials would be called upon to play would be a major one, and so these categories are receiving top priority in planning from the very start.

The entire program is based upon the national program laid down by Washington as a pattern for state and local groups. There are five areas in the state, each with its own commanding colonel. They are: No. 1, Cincinnati, Colonel Sam Richmond; No. 2, Columbus, Colonel Edgar A. Silbaugh; No. 3, Youngstown, Colonel Donald J. Lynn; No. 4, Kenton, Colonel Cecil J. Davis; No. 5, Cleveland, Colonel Frank C. Manik.

Executive director for the program is Dr. William E. Warner of Ohio State University. Dr. Warner is a veteran of World Wars I and II and was in charge of a similar civil defense move in Europe.

During the last war the council was headed by Ralph Stone, now with the Veterans Administration. Under that set-up the council had more divisions than the present one.

ADVISORY GROUP

Adj. Gen. Leo Kreber is chairman of the council and Governor Frank J. Lausche is vice-chairman. In establishing a plan for the state Governor Lausche has named an 11-man advisory group to aid in planning all matters pertaining to the problem. The advisors will receive no pay for their services, but will be allowed expenses incurred in their duties.

This advisory group includes: Veterans, Ralph Stone; Mayors, Michael DiSalle; County Commissioners, Oliver Kuhn; Health and Medicine, Dr. John D. Porterfield, State Director of Health; Agriculture and Food, Joseph W. Fichter; Labor, Phil Hannah; Manufacturing, A. S. Gentholts; Communication, Randolph Eide; Transportation, Raymond J. Lewis; Procurement and Salvage, Ralph Lazarus; American Red Cross, John S. Rolfes.

HEALTH-MEDICAL ORGANIZATION

Realizing the extent his division will be called upon in case of enemy attack, Dr. Porterfield has named a 15-member group to cover as many of the phases of health and medical care as possible. These men are representatives of the various state associations dealing with the problems likely to be confronted. They are: Dr. C. C. Sherburne, Columbus, chairman of the Ohio State Medical Association's Committee on National Emergency Medical Service, medical; Dr. J. O. Watson, osteopathic; Miss Clara Brouse, nurses board; Mrs. Elizabeth P. August, nurses association; Nelson Carpenter, pharmaceutical; Dr. A. E. Luckhard, dental; Erwin C. Pohlman, hospitals; Jerry Gordon, funeral directors; and Dr. J. H. Drayer, public health sanitation.

Dr. C. W. Greenlee, Rayland, veterinary medicine; Dr. Carl A. Wilzbach, Cincinnati, public health; John F. Rolfes, Bloomdale, general field agent for Red Cross eastern area; Dr. S. R. Gerber, Cleveland, secretary of the Ohio Coroners' Association, county coroners; W. R. LaDue, Akron, American waterworks; and A. H. Niles, Toledo, Federal sewage works.

DIVISION HEADS

Four division heads have been named. They are: Medical Care, Dr. Porterfield; Sanitation, F. H. Waring; Public Health, Dr. Paul Q. Peterson; Professional Training, Dr. R. E. Dwork. These four divisions will each have its own area in which to operate.

The Medical Care group will inventory and classify all personnel and equipment throughout the state. The Sanitation people will make a survey of sewage and water supply systems, with a complete plan for alternate supplies in case of disruption of present facilities due to bombing or other causes. This group also will develop a system for protection against bacteriological warfare.

The Public Health division will set up for emergency communicable disease control as well as establishing a system to attempt to decrease occupational hazards during wartime.

The group in charge of professional training has three distinct fields of activity. First, it will have the job of developing a system of coordination of various aspects of civil defense. Second, it will publish a periodical to be sent to all local civil defense officials, and third, it will develop and assemble material to be turned out by the press relations office.

Just as the Federal government is establishing a national-scale plan for state defense councils to follow, so is the state council developing a plan to be followed by local councils and groups throughout Ohio. This will aid in establishing an

over-all form to the defense picture, and will facilitate the moving of disaster units into cities or localities that have been hard hit from others that were not attacked.

"One of our biggest jobs," Dr. Porterfield said, "will be in educating the people themselves. In the event of an atomic bomb attack, huge numbers of volunteers will be needed. But no number of volunteer workers will be of aid unless they have some conception of what is needed and how to go about assisting the emergency teams which move into the area."

COUNTY SOCIETY PARTICIPATION

On July 27 Dr. E. O. Swartz, President, Ohio State Medical Association, issued a call requesting all county medical societies to immediately establish Committees on Emergency Medical Care. These committees will serve as local components of the Committee on National Emergency Medical Service of the Ohio State Medical Association; advise and cooperate with local defense units; help work out and administer a proper health and medical program for the protection of civilians in case of enemy attack, or some other emergency; submit recommendations and suggestions on local activities to the committee of the Ohio State Medical Association which, in turn, can take up such matters with the State Defense program officials.

As this issue went to press 74 county societies had named emergency committees.

With the national, state, and local civil defense programs moving ahead rapidly, it is imperative that the remainder of these committees be set up as quickly as possible.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since June 13, 1950. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

CLARK COUNTY
Clyde E. Asbury, Jr., Springfield
Robert A. McLemore, Springfield

CUYAHOGA COUNTY
Leonard A. Backiel, Cleveland
Bernard A. Ceraldi, Cleveland
Robert E. Rinderknecht, Cleveland
Homer T. Yoder, Cleveland

ERIE COUNTY
John F. Grant, Sandusky

FRANKLIN COUNTY
Robert H. David, Columbus

GREENE COUNTY
E. J. Schmitt, Xenia

GUERNSEY COUNTY
Elizabeth B. Smith, Cambridge
Howard F. Van Noate, Cambridge

MIAMI COUNTY
Dale A. Hudson, Piqua

MONTGOMERY COUNTY
A. J. Gabriele, Dayton

MORGAN COUNTY
Frank Lande, McConnelsville

VINTON COUNTY
Dean F. Hammond, McArthur



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Rural Medical Scholarship . . .

Second of the State Association's Awards To Stimulate Interest in Country Practice Presented by Committee to Lawrence County Youth

A LAWRENCE County youth, 27-year-old Robert G. Smith, of Proctorville, has been selected as the winner of the second annual Ohio State Medical Association Rural Medical Scholarship.

The award was made by the Association's Committee on Rural Health under the chairmanship of Dr. J. Martin Byers, of Greenfield. In a public announcement to the press, Dr. Byers explained that the scholarship was created with the idea of encouraging rural young men and women to take up the study of medicine in the hope that they will become country doctors and help supply the needs of Ohio rural areas.



R. G. SMITH

Smith, who is a combat veteran of World War II, will receive $500 each year during his four-year medical course, provided he remains in good standing. He completed his premedical work at Ohio State University, graduating cum laude in the class of 1950. He will become a student at the Ohio State University College of Medicine this fall.

Under the scholarship plan, which was instituted a year ago by the State Medical Association, one student is selected each year. A farm or a rural small town community background as well as a sincere desire to take up a rural practice are of prime importance in making the selection.

Smith has an excellent record in rural youth work, including the Proctorville 4-H Club, the Epworth League, and he was for three years assistant advisor to the Baptist Rural Youth League. He is a 4th degree member of Windsor Subordinate Grange, a 5th degree member of Lawrence County Pomona Grange and has received the 6th degree of the Ohio State Grange.

During the summer vacations of his high school years he worked on local farms and in the orchards near his home town.

While attending the Ohio State University he was a member of Alpha Epsilon Delta, honorary premedical fraternity. As a graduate of Proctorville High School in the class of 1941 he received the Good Scholarship medal.

Smith served three and one-half years in the Armed Services and held a first lieutenant's commission at the close of the war. He was a pilot attached to the 301st Airborne Division of the China-Burma-India theater.

Married and the father of two children, Smith plans to return to his home town to practice medicine. Commenting on his desire to practice in a southern area of the State, he said: "Both my wife and I come from Proctorville. We know the people and we have seen their needs. They need doctors in that area, and I want to help in any way possible. I want also to have my children brought up in a rural environment. It's a wholesome one."

Last year's winner, C. Craig Wright of Winterset, Guernsey County, Ohio, who will be a sophomore at the Ohio State University College of Medicine, has received his second $500 check. After the 1951 and 1952 awards have been made, four students will be receiving checks every year.



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In Memoriam . . .

Mary E. Anderson, M. D., Mansfield, Mass.; Michigan College of Medicine and Surgery, 1896; aged 86; died July 19. Dr. Anderson practiced in Hudson before retiring several years ago. Two sons survive.

Joseph Emil Blunden, M. D., Pasadena, Calif.; Medical College of Ohio, Cincinnati, 1903; aged 76; died June 14; former member of the Ohio State Medical Association and the American Medical Association through 1944. A former practicing physician in Cincinnati, Dr. Blunden has made his home in California for the past 12 years.

Harold A. Campbell, M. D., Newark; Ohio State University College of Medicine, 1924; aged 51; died August 8; member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1949; secretary-treasurer of the Licking County Medical Society, 1926-29; vice-president in 1930 and 1932, and president in 1931; member of the American Association of Industrial Physicians and Surgeons. Dr. Campbell had practiced in Newark beginning in 1924.

Frank P. Charvat, M. D., Cleveland; Western Reserve University School of Medicine, 1896; aged 75; died July 28; former member of the Ohio State Medical Association and the American Medical Association through 1936. After studying abroad, Dr. Charvat took up his practice in Cleveland, but retired a number of years ago because of ill health. Recently he was awarded the 50-Year Pin and Certificate of the Ohio State Medical Association through the Cleveland Academy of Medicine. He was a member of the Catholic Church. Surviving are his widow, a daughter and a son, Dr. Thomas F. Charvat, also of Cleveland.

Robert B. Cofield, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1903; aged 72; died July 14; member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1949; member of the American Orthopaedic Society, the Clinical Orthopaedic Society, the American Academy of Orthopaedic Surgery and the American College of Surgeons. Dr. Cofield's long practice and activities in Cincinnati included a number of years as president of the medical staff of Christ Hospital and participation in organizing the orthopedic staff there. He was one of the founders of the Condon School for Crippled Children and was consulting orthopedic surgeon at Children's Hospital. He also was a trustee of the National Foundation for Infantile Paralysis. Surviving



are his widow, three daughters and a son, Dr. Robert H. Cofield, of Newtown.

Cassius Guy Dew, M. D., Nelsonville; Ohio Medical University, Columbus, 1903; aged 71; died July 9; former member of the Ohio State Medical Association and the American Medical Association through 1948; vice-president of the Athens County Medical Society in 1927 and its president in 1928. Dr. Dew had practiced medicine in Nelsonville for more than 40 years prior to his retirement because of illness about two years ago. In addition to his practice he was active in public and business life. At one time he was chairman of the Athens County Democratic Executive Committee and served as mayor of Nelsonville. A veteran of World War I, he was a member of the American Legion. He held memberships in several Masonic orders, was a member of the Order of Eagles, the Elks and the Knights of Pythias. Surviving are two sisters and a brother.

E. Paul Greenawalt, M. D., Springfield; Johns Hopkins University School of Medicine, 1920; aged 55; died July 29; member of the Ohio State Medical Association and a Fellow of the American Medical Association; secretary of the Clark County Medical Society in 1927, vice-president, 1933, and president in 1934; fellow of the American College of Surgeons. Dr. Greenawalt had practiced in Springfield for approximately 25 years. In addition to his medical career, he was active in several fraternal and civic organizations. He was a past-master of the Masonic Lodge and held membership in several Masonic orders, the Lutheran Church and Beta Theta Pi. He was a veteran of World War I. Surviving are his widow and two sisters.

Vernon L. Hart, M. D., Minneapolis, Minn.; University of Michigan Medical School, 1924; aged 52; died early in July; former member of the Ohio State Medical Association through 1933 and a Fellow of the American Medical Association. Dr. Hart moved his practice from Dayton to Minneapolis in 1933.

Henry L. Hinkley, M. D., Green Springs; The Hahnemann Medical College & Hospital, 1887; aged 92; died August 10; former member of the Ohio State Medical Association and the American Medical Association through 1925. Dr. Hinkley formerly was health commissioner for Seneca County. Two daughters and three sons survive.

Lewis Wade Heizer, M. D., Norwood; University of Cincinnati College of Medicine, 1910; aged 66; died July 30; former member of the Ohio State Medical Association and the American Medical Association through 1929. Dr. Heizer was assistant health commissioner for Cincinnati from 1919 to 1921.

Jonathan Kelley James, M. D., Delaware; Ohio Medical University, Columbus, 1897; aged 82;

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died July 26; former member of the Ohio State Medical Association and the American Medical Association through 1946; president of the Delaware County Medical Society in 1926 and 1935 and its president in 1940 and 1941. Dr. James' many years of practice in Delaware were recognized recently when he was presented the 50-Year Pin and Certificate of the Ohio State Medical Association through the Delaware County Medical Society. He had retired from active practice in 1946. He was a member and trustee of the Methodist Church and a member of the Masonic Lodge. His widow survives. Dr. James' only son, Dr. Dorrance S. James, died in May of this year.

William E. Kulka, M. D., Cleveland; University of Vienna, Austria, 1905; aged 70; died July 19; member of the Ohio State Medical Association and the American Medical Association; member of the American Society of Clinical Pathologists; the Ohio State Society of Pathologists and the Cleveland Society of Pathologists. A native of Austria, Dr. Kulka served as a medical officer in the Austrian Army during World War I. From 1919 until 1939 he maintained private practice and also was a senior health officer of the city of Vienna. Following the Nazi invasion of Austria, he came to this country with his family in 1939, and served successively as pathologist and director of the blood bank at Our Savior's Hospital, Jacksonville, Ill., and head of the laboratories of the Millard Fillmore Hospital, Buffalo, N. Y. In 1944 he joined the coroner's staff in Cleveland and became head of the laboratory of pathology and forensic medicine. Dr. Kulka was the author of more than 40 medical papers both in the U. S. and abroad. He is survived by his widow and two sons.

Edward B. Markey, M. D., Dayton; Cornell University Medical College, 1906; aged 71; died July 19; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1947. Dr. Markey retired from active practice about two years ago after a long practice in Dayton. He formerly practiced also in Butler and Preble counties. He held memberships in the Episcopal Church and the Masonic Lodge and was an honorary member of the Mercator Club. Surviving are his widow, a daughter, and a son, Dr. Robert C. Markey, also of Dayton.

William D. Micklethwait, M. D., Portsmouth; Medical College of Ohio, Cincinnati, 1901; aged 75; died August 8; member of the Ohio State Medical Association and a Fellow of the American Medical Association; vice-president of the Hempstead Academy of Medicine in 1932 and its president in 1937. Dr. Micklethwait began practice in Portsmouth in 1902. He retired in 1940, but resumed practice during the war. In addi-

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tion to his medical practice he was interested in real estate development projects in Portsmouth. He also was medical examiner for three insurance companies. Activities included memberships in the Methodist Church and the Masonic Lodge. Surviving are his widow, two sons, a sister and a brother, Dr. Oscar O. Micklethwait, also of Portsmouth.

George B. Nessley, M. D., Columbus; Ohio Medical University, Columbus, 1894; aged 81; died July 26; member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1949. Dr. Nessley had practiced medicine in the Hilltop area of Columbus for approximately 54 years. He was a member of the Methodist Church and was a director of the First Federal Savings & Loan Association. Surviving are his widow, a daughter and a sister.

Leo George Reuscher, M. D., Pleasant Ridge; University of Cincinnati College of Medicine, 1911; aged 67; died July 9; member of the Ohio State Medical Association and the American Medical Association through 1919. In addition to his practice, Dr. Reuscher formerly operated a drug store in Cincinnati and at one time was associated with the Cincinnati Board of Health. He is survived by his widow, five sons, a brother and a sister.

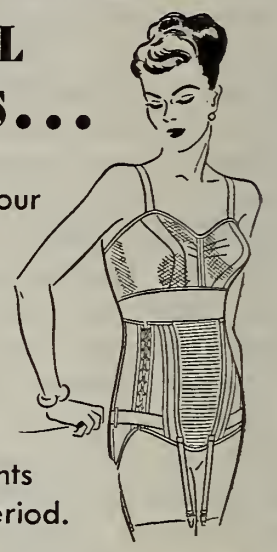
Joseph Perry Weiss, M. D., Akron; Ohio State University College of Medicine, 1927; aged 57; died July 4; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Weiss began practice in Akron in 1928. He was a member of the Methodist Church. Surviving are his widow, two brothers and a sister.

Wilmington—Dr. Edward B. Headley has been appointed commissioner of the Clinton County Health District which includes the city of Wilmington. An Ohioan, Dr. Headley received his degree from Johns Hopkins Medical School in 1949.

Dr. Harrison S. Collisi, manager of Crile Veterans Administration Hospital since September of 1946, has been transferred to head the V. A.'s new 200-bed general hospital at Erie, Pennsylvania. The transfer is effective December 1.

Xenia—The following were elected by the staff of the Greene County Memorial Hospital: Dr. Harold E. Ray, chief of staff; Dr. P. B. Wingfield, vice-president; Dr. C. G. McPherson, secretary; Drs. W. T. Ungard, S. C. Ellis and L. W. Sontag to the executive committee.

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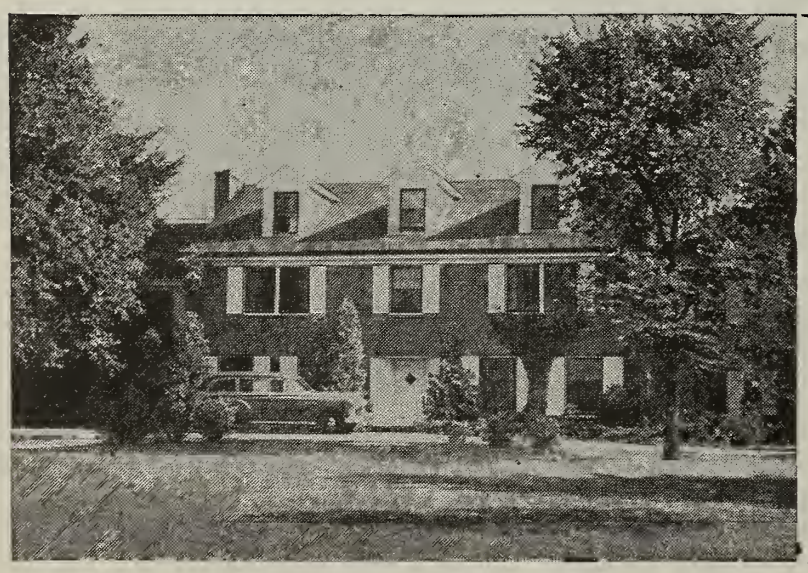
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Do You Know? . . .

Toledo's Dr. Edward J. McCormick, A. M. A. Board of Trustees member, has been appointed a trustee of the Elks National Foundation. For the past several years this foundation has been granting college scholarships and doing other work on the national and state levels.

* * *

The Royal College of Surgeons at London, England, has announced the awarding of an honorary fellowship to Dr. Derrick T. Vail, former head of the department of ophthalmology at the University of Cincinnati. The award was made in recognition of Dr. Vail's "outstanding service to medicine."

* * *

Dr. William A. Altemeier, of the College of Medicine at the University of Cincinati, has been appointed a member of the National Research Council. Dr. Altemeier is the first U. C. faculty member to be named to the Washington Council. He is an assistant professor of surgery and graduated from College of Medicine at U. C. in 1933.

* * *

More than 80 present and former members of the surgery department at Western Reserve University Medical School honored Dr. Carl H. Lenhart this summer. The testimonial was held at Lakeside Hospital and marked Dr. Lenhart's retirement after 18 years' service.

* * *

Dr. D. A. Dukelow of Chicago, health education advisor to the American Medical Association, has been named to assist in the preparation of health data for the Midcentury White House Conference on Children and Youth. Dr. Dukelow's appointment was anounced by Melvin A. Glasser, executive director of the conference.

* * *

Dr. Francis R. Manlove, Philadelphia, has been appointed associate secretary of the A. M. A. Council on Medical Education and Hospitals. He is assistant professor of medicine at Temple University School of Medicine and chief of medical service B at Episcopal Hospital.

* * *

The first national blood bank survey, made under direction of Dr. Frank G. Dickinson, director of the A. M. A's Bureau of Medical Economic Research, and reported at the A. M. A. Session in San Francisco, showed that 1,636 blood banks and centers are in operation in the United States. They are located in 951 cities. Inventory showed a current supply of 76,000 pints. About 61,300 pints are in hospital blood banks, 6,100 are in Red Cross regional centers and 8,100 in nonhospital blood banks.

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Buckeye News Notes . . .

Cleveland—Dr. Fiorindo A. Simeone has been appointed head of surgery at City Hospital, succeeding Dr. C. H. Lenhard, who recently retired. Dr. Simeone comes from Harvard Medical School and Massachusetts General Hospital.

Cleveland—Dr. Jess J. Woodworth has been named head of the Department of Obstetrics and Gynecology at Huron Road Hospital.

Cleveland—Dr. I. M. Hinnant, representing the Cleveland Academy of Medicine, addressed the Churchmen's League of Cleveland on Socialized Medicine. Dr. Hinnant spoke before a luncheon meeting of the group.

Cleveland—The promotion of Dr. Thomas D. Kinney to professor of pathology at City Hospital has been announced. The promotion was announced by Welfare Director Edward L. Worthington and Western Reserve University President John S. Mills. Dr. Kinney joined the staff in 1947, coming from an associate professorship of pathology at Peter Bent Brigham Hospital at Boston.

Forest—Two local physicians—Dr. J. F. Holtzmuller and Dr. E. J. Clinger—endorsed for doctors a visit of the Red Cross Bloodmobile due at this city on Sept. 25.

Grover Hill—Dr. T. P. Fast was honored recently as one of the foremost family doctors at a community gathering sponsored by the Lions Club. Dr. Fast began his practice in Grover Hill in May of 1900. He was presented a gift by his "first baby" and another by the Lions Club.

Jackson—Dr. William B. Taylor has announced that he will leave his practice in Jackson to accept an appointment at University Hospital, Ann Arbor, Mich.

Oberlin—A meeting was held with the objective of laying plans for a hospital to serve the southern third of Lorain County.

Painesville—The Lake County Memorial Hospital staff entertained members of the medical societies of Ashtabula, Geauga Counties and their wives on July 19. In charge of arrangements were Dr. F. J. Dineen, Dr. G. Robert Smith and Dr. John W. Davis.

Toledo—Dr. Byron Grant Shaffer has been named director of surgery at St. Vincent's Hospital to succeed the late Dr. Fred M. Douglass.

Toledo—The American Proctological Society this summer awarded Drs. Bernard Steinberg and William Blank of Toledo a $100 prize for their paper on methods of detecting cancer and other work being done at the Toledo Hospital Institute for Medical Research. The award was made at the society's Los Angeles meeting.

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GYNECOLOGY—Intensive Course, two weeks, starting Sept. 25, Oct. 23. Vaginal Approach to Pelvic Surgery, one week, starting Sept. 8, Nov. 6.

OBSTETRICS—Intensive Course, two weeks, starting Sept. 11, Nov. 6.

MEDICINE—Intensive General Course, two weeks, starting Oct. 2. Gastro-enterology, two weeks, starting Oct. 16. Gastroscopy, two weeks, starting Sept. 11, Oct. 23. Electrocardiography & Heart Disease, four weeks, starting Oct. 2.

DERMATOLOGY—Formal Course, two weeks, starting Oct. 16. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, two weeks, starting Sept. 25. Cystoscopy, Ten Day Practical Course, every two weeks.

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Activities of County Societies . . .

ADAMS

The Adams County Medical Society held a meeting at the Museum, Serpent Mound State Park, on Aug. 17, at which families of doctors were guests. Dr. S. J. Ellison, West Union, gave a report of the State Meeting. Guest speaker was Dr. Robert M. Woolford, Cincinnati, who spoke on "Antibiotics." Dr. and Mrs. R. B. Ellison, Peebles, were hosts at a picnic dinner.

CLINTON

The Clinton County Medical Society has appointed a seven-member committee to obtain data on the organization of staffs, looking forward to the formation of a staff for the Clinton Memorial Hospital now under construction in Wilmington.

GREENE

The regular monthly meeting of the Greene County Medical Society was held on July 13. Dr. H. B. Elliott, Springfield, spoke on the subject, "Ovarian Tumors."

A special meeting of the Society was held on July 27 to organize a staff for the nearly completed Greene County Memorial Hospital. Dr. Harold E. Ray was elected president of the staff. The staff will hold monthly meetings on the fourth Tuesday at 8 p. m.

The Society played host at a stag picnic on August 9 to dentists, lawyers and pharmacists of the county. The program and public relations committees joined in promoting the affair.—Ray W. Barry, M. D., Pres.

HURON

Members of the Huron County Medical Society entertained their wives at a dinner at the Elks Country Club on June 21. After dinner the group drove to the home of Dr. and Mrs. Byron T. Merrick in Berlin Heights where Dr. Merrick gave an informative talk based on his collection of Swiss music boxes.

LAKE

Dr. Alan R. Moritz, professor of pathology at Western Reserve University School of Medicine, spoke at the annual dinner of the Lake County Memorial Hospital staff held at the Madison Golf Lakelands Club House on July 19. His subject was "The Unexplained Death." The speaker advocated that communities should have agencies to screen unexpected, accidental and obscure deaths. He stressed the importance of having deaths of that nature investigated by competent medical examiners, trained in pathology. Twelve per cent of persons who seem to have died unexpectedly of undiscovered causes have died of violence. Pseudo-accidents and pseudo-suicides which give all the outward ap-

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pearances of being accidents and suicides, upon investigation may prove to be homicidal crimes, the speaker declared.

Dr. Paul Reading presided at the dinner and the guest speaker was introduced by the program chairman, Dr. F. J. Dineen.

Woman's Auxiliary . . .

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SPECIAL NOTICE

To All County Presidents Who Have Not Sent in Names and Addresses of Officers and Chairmen:

May we remind you of the importance of sending in, immediately, to Mrs. Oscar Jepsen, corresponding-secretary, and to your district director, the complete names and addresses of all your local officers and chairmen of committees.

Mrs. George Cooperrider, state president, urges that this be given attention **at once.** Where correct names are not available, there is regrettable delay in necessary and important information and materials reaching those for whom that information is intended.

FALL DISTRICT MEETINGS

Here is the schedule of fall district meetings.

District 1—Sept. 26, Hillsboro—Luncheon

District 2—Oct. 18, Dayton—Luncheon, Biltmore Hotel

District 3—Oct. 20, Marion—Luncheon, Hotel Harding

District 4—Oct. 26, Toledo

District 5—Nov. 14, Cleveland—Luncheon, Westwood Country Club

District 6—Sept. 29, Warren—Luncheon, Hotel Warren

District 7—Oct. 10, Steubenville — Luncheon, Country Club

District 8—Oct. 5, Newark—Luncheon, Country Club

District 9—Oct. 12, Portsmouth—tea, Chez Paree

District 10—Oct. 23, Columbus—Luncheon, Seneca Hotel

District 11—Sept. 14, Elyria—Luncheon, Country Club

It is with deep regret that we call attention to the great loss suffered recently by our vice-

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president, Mrs. E. Paul Greenawalt. Dr. Greenawalt died suddenly on July 29. The Woman's Auxiliary extends its deepest sympathy.

Because of the usual cessation of activities for the most part during the summer months, there are no county auxiliary news items to record other than the luncheon, held in July, by the Meigs County Auxiliary. Mrs. Roger Daniels was hostess. Plans were made for an outdoor luncheon to be held at the home of Mrs. William Jeric in August.

A Second Pamphlet Promotes Truman Health Plan

Campaigners for national health insurance now have new ammunition. The latest propaganda effort from Democratic National Committee is a detailed handbook for party workers, designed to supplement a smaller, mass-appeal pamphlet already circulating in the hundreds of thousands. The first pamphlet, *Better Medical Care That You Can Afford*, is a smartly edited, overly simplified three-color job, which undertakes with a few words and numerous drawings to sell the general public on the advantages of compulsory national health insurance. It is enjoying wide circulation, mostly as a result of bulk-quantity purchase by labor unions and other organizations and direct mailing by the National Committee.

The latest booklet is pitched to a different population level. It dips a little deeper into the subject, and supplies adequate material for speeches, radio talks, group discussions, etc. This second pamphlet is entitled *Administration Health Program, a Training Kit for Leaders.* Although the material consists mostly of the familiar mixtures of information and propaganda, it is well arranged to simplify the job of the party worker. The 80 pages are broken up by sections, headings and bold face type, and an index, resume and cross-reference system are provided.

The section on lobbying is a 17-page attack on American Medical Association, usually referred to as Organized Medicine. Included are 36 questions, such as "Is It True That America Has 'Low Grade' Health Care?" Answers to each are printed in parallel columns under the headings "Lobbyists Say" and "The Truth Is."

A ready guide for speakers is provided in the last chapter. This consists of liberal quotations from various messages and speeches of the President, a statement by E. S. A. Administrator Oscar Ewing and advice on how best to appeal to special population groups, such as housewives, farmers, industrial workers, Negroes, businessmen. One section tells party workers what arguments to use when they attempt to convince doctors that national health insurance would be to their advantage.

New Nursing School

Capital University at Columbus has announced the establishment of the Capital University School of Nursing. The school has been approved by the Ohio State Nurses Board. The program comprises a 51-month curriculum and leads to the degree of Bachelor of Science in Nursing, the university announcement said.

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Health Situation in Korea Headache For Medical Officers

To date not much information has been announced on the rate and type of casualties in Korea. However, an Army spokesman gives this picture: Medical supplies, equipment and personnel are in the combat area in sufficient quantity to meet our responsibilities. On the scene are evacuation hospitals, mobile "clearing companies" (division hospitals) and mobile surgical hospitals, all "in adequate supply and operating."

Casualties whose wounds indicate they will not be able to rejoin their units for 120 days are sent back to the United States, others hospitalized in Japan or Korea. The Far Eastern Field Surgeon, Major Gen. Edgar Erskine Hume, anticipates a high rate of psychoneurotic cases because of the nature of the fighting.

Disease rates probably have gone up under combat conditions. Under any conditions, Korea is considered an "unhealthy" place—better than some Far Eastern countries but worse than others. There is virtually no control of the water supply, and human waste is used for fertilizer, as in most countries in that area. Water is unsafe for drinking or bathing.

Despite these conditions, the troop disease rate during our four years of occupation was "not significantly higher" than elsewhere. This was due to health discipline measures which are of limited effect during combat. Increases are expected in malaria, scrub typhus, diarrhea and intestinal and other diseases. Adequate supplies of proper drugs are on hand to fight this, including chloroquine, chloromycetin and dramamine.

Changes Made In Division of Aid For Aged Fee Schedule

Several changes in the medical fee schedule of the Division of Aid for the Aged have been announced, effective as of August 15.

The amount paid for an intravenous injection will be the fee for the home call or office or hospital visit, plus a flat amount of $1.50. The amount paid for an intramuscular injection will be the fee for the call or visit, plus a flat amount of $1.00.

Also, the division announced that penicillin will no longer be allowable as an item chargeable over and above the fee for the call or visit but will be considered as ordinary medication and will be included in the cost of the call or visit.

The American Social Hygiene Association estimates that there are approximately 100,000 children in the U. S. suffering from congenital syphilis.

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COMING MEETINGS

A. M. A. Clinical Session, Cleveland, December 5-8

International College of Surgeons, U. S. Chapter, Annual Assembly, Cleveland, October 31-November 3.

Medina Community Hospital, Scientific Program, Westfield Country Club, LeRoy, October 4.

St. Luke's Hospital, Symposia, Cleveland, September 20.

Sixth Councilor District Postgraduate Day, St. Francis Hotel, Canton, October 4..

Ohio Society of Allergists, Seneca Hotel, Columbus, October 7-8.

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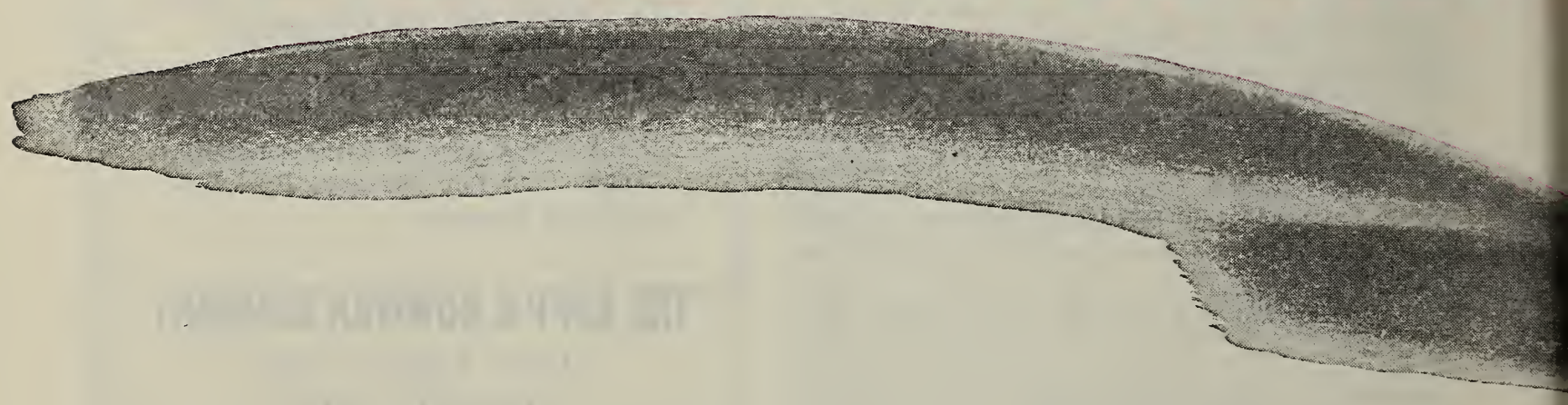
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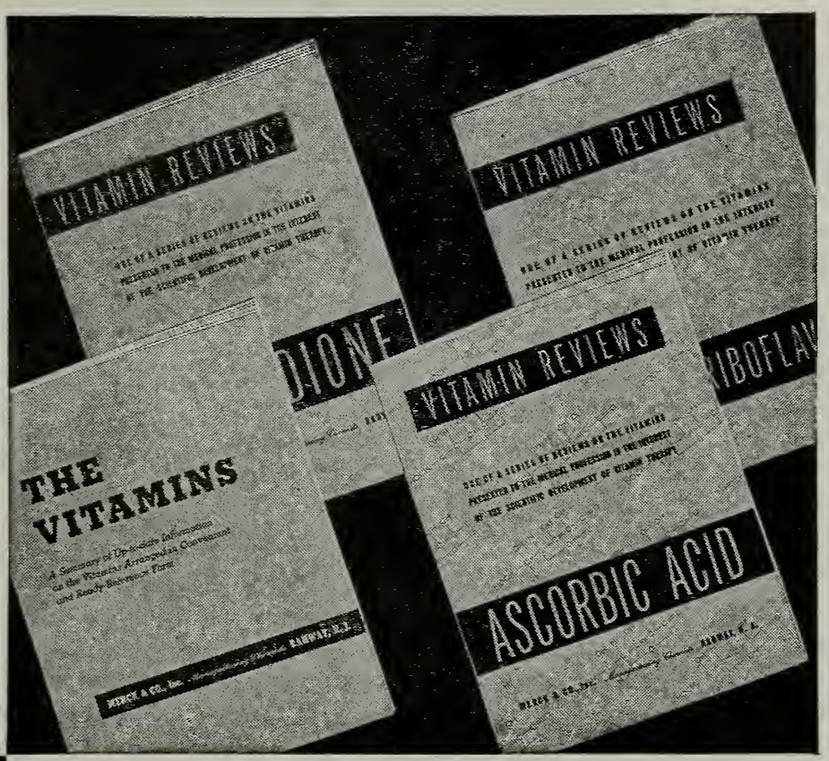
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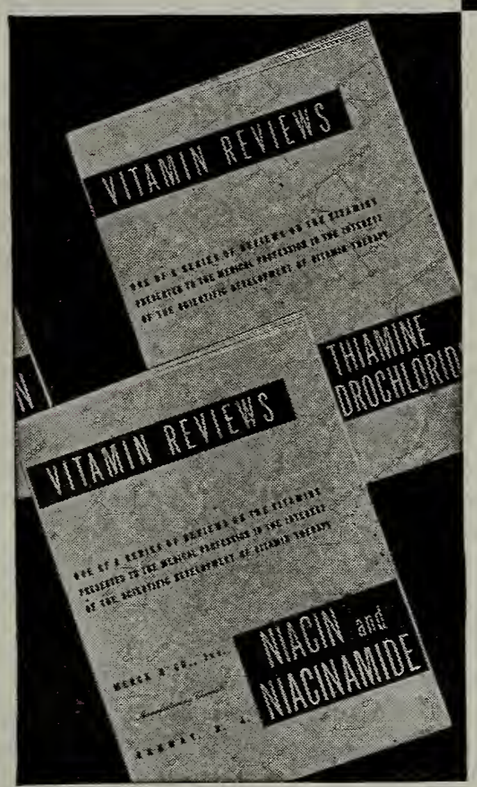


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The Physician's Bookshelf

By Jonathan Forman, M.D.

The Cytologic Diagnosis of Cancer, by the staff of Vincent Memorial Laboratory at the Massachusetts General Hospital ($6.50. *W. B. Saunders Co., Philadelphia),* sets forth the actual experiences of this staff of competent workers in their attempt to diagnose cancer by the changes they have found in cells.

Thrombosis in Arteriosclerosis of the Lower Extremities, by Edward A. Edwards, M. D. ($2.00. *Charles C. Thomas, Publisher, Springfield, Ill.),* is another one of those attractive small monographs in the American Lecture Series. This method of presenting reviews and practical material should be encouraged by all of us in every way.

Surgery of the Mouth and Jaws, by J. Ray Bourgoyne, D. D. S. ($12.00. *Dental Items of Interest Publishing Co., Brooklyn, N. Y.),* will be an invaluable aid to the surgeon who wishes to acquire surgical technique and study procedures without the necessity of reading a multitude of volumes on this subject. In this one volume he will find all of the essential facts well organized and presented in a logical and understandable manner.

BCG Vaccination in Theory and Practice, by K. Neville Irvine ($3.00. *Blackwell Scientific Publications, Oxford, England),* is a succinct review of the literature in an objective manner of this controversial subject which seems to mean more in backward countries than in countries with higher levels of living standards.

Handbook of Obstetrics and Diagnostic Gynecology, by Lee Doyle, M. D. ($2.00. *University Medical Publications, P. O. Box 761, Palo Alto, Calif.),* is neither a textbook nor one of reference. It is strictly a handbook. A nice thing for the intern or senior student on the service to have in his pocket. A nice little gift for him just before he goes on duty. He will be too busy to consult larger books.

Medical Gynecology, by James C. Janney, M. D. ($6.50. Second edition. *W. B. Saunders Co., Philadelphia),* makes a strenuous attempt to incorporate the important physiologic and pathologic considerations as well as to correlate the academic picture of disease with the complaints in the physician's office of a patient coming with that particular disease.

Advances in Pediatrics, edited by S. Z. Levine, A. M. Butler, L. E. Holt, Jr., and A. A. Weech ($6.50. Volume IV. *Interscience Publishers, Inc., New York City),* consists of seven personalized monographs by authoritative contributors; "Diet in Infancy" by A. Lichtenstein of Stockholm; "Treatment of Congenital Syphilis with Penicillin" by Ralph V. Platon of New Orleans; "Erythema Nodosum" by Ruth T. Gross and Rustin McIntosh of New York; "The Reticulo-Endotheliosis of Children" by Sture Siwe of Lund, Sweden; "Combined Immunizations" by Joseph H. Lapin of New York; "Subdural Hematoma in Infancy" by Franc D. Ingraham and Donald D. Matson of Boston; "Cystmosis in Children" by E. Freudenberg of Basle, Switzerland. All this makes a most valuable volume.

Hormones in Clinical Practice, by H. E. Nieburgs, M. D. ($5.00. *Paul B. Hoeber, Inc., New York City),* is more than a refreshing survey of the field. This book has as its objective a fresh evaluation of the therapeutic procedures involving the use of hormones and those directed to a correction of endocrine disturbances.

Clinical Diagnosis by Laboratory Examinations, by John A. Kolmer, M. D. ($12.00. Second edition. *Appleton-Century-Crofts Co., Inc., New York City),* has been heavily revised and meritably enlarged by inclusion of newer material. Most physicians will want to own a copy to help them use their laboratory facilities. Every intern library must have this book.

The Meaning of Human Existence, by Leslie Paul ($3.00. *J. B. Lippincott Co., Philadelphia),* discusses the subject in terms of the mystique of Progress upon which all Western political doctrines were founded. The author believes that the real crisis in the world today lies in the failure of man's idea of himself. You will enjoy this book as the world is tumbling down around you.

Hutchinson's Food and the Principles of Dietetics, revised by V. H. Mottram, M. D., and George Graham, M. D. ($6.75. Tenth edition. *Williams & Wilkins Co., Baltimore,* Md.), presents an almost new section on "Diet in Normal Life." A reference book which many of us will consult often.

Atlas of Human Anatomy, Descriptive and Regional, by M. W. Woerdeman, M. D. ($10.00. *Blakiston Company, Philadelphia),* is Volume I of the series, and naturally deals with osteology, arthrology and myology, so graphically presented because "of the increasing scarcity in many countries of anatomical material for the dissecting room." The excellent figures have all been drawn according to dissection of the adult human body.

Proceedings of the First Clinical ACTH Conference, John R. Mote, M. D., editor ($5.50. *Blakiston Company, Philadelphia),* gives promptly the information brought out in an informal conference of those who have been given this material for research into its nature and its uses. Many papers now appearing in medical journals should be brought out in this form to relieve the great backlog of manuscripts that most medical journals have today.

Biological Actions of Sex Hormones, by Harold Burrows ($8.50. Second edition. *Cambridge University Press, New York City),* carries out well the intentions of the author to collect facts and coordinate them so that the subject of sex hormones may be regarded broadly without obscurity derived from unconfirmed ideas.

Urologic Roentgenology, by Miley B. Wesson, M. D. ($7.50. Third edition. *Lea & Febiger, Philadelphia),* is an excellent volume for the physician who wishes to study the films of his patient, and "for the urologist or roentgenologist preparing for Specialty Board examinations." (God save us from books for that purpose.)

Clinical Radiation Therapy by Ernest A. Pohle, M. D. ($15.00. Second edition. *Lea & Febiger, Philadelphia),* has 19 other contributors, and 202 illustrations and places the accent strictly on the clinical aspects of the subject. The book is, therefore, for the practitioner.

Gastroscopy, by Rudolf Schindler, M.D., ($20.00. Second edition. *University of Chicago Press, Chicago, Ill.),* has contributed much to our understanding of gastric disease and its diagnosis. The author introduced the subject into America and wrote the first edition of this book in 1937. This then is "the bible" of endoscopic studies of gastric pathology.

Methods in Medical Research, edited by J. H. Comroe, Jr., ($6.50. Volume II. *Year Book Publishers, Chicago, Ill.),* has to do witn the present-day methods used in the investigation of Bacterial Viruses, Pulmonary Function Tests, and Assay of Hormone Secretions. It is the laboratory manual of the investigation in these fields.

Progress in Clinical Endocrinology, edited by Samuel Soskin, M. D. ($10.00. *Grune & Stratton, Inc., New York City),* is a book appealing to all physicians in active practice. Its score of contributors reads like a blue book of endocrinologists.

A Pattern for Hospital Care, by Eli Ginzberg ($4.50. *Columbia University Press, New York City),* is the final report of the New York State Hospital Study. This report gives us a broad view of what the experts in hospital administration think as well as the views of the public. A book of advice of a statesman and public spirited citizen.

Principles of Human Genetics, by Curt Stern *(W. H. Freeman & Co., San Francisco, Calif.),* is a college text on this rapidly expanding subject. Those of us who are losing out in following its progress will do well to read this text.

Community Health Organization, by Ira V. Hiscock ($2.75. Fourth edition. *The Commonwealth Fund, New York City).* The author is well known to our readers for his survey of the needs for the care of the sick in Metropolitan Columbus and his study of the "Athen's project." This is the current edition of the standard text of reference.

Helpful Hints to the Diabetic, by William S. Collens, M. D., and Louis C. Boas, M. D. ($3.00. *Charles C. Thomas, Publisher, Springfield, Ill.).* This book is derived from the authors' long and large experiences in answering questions asked by patients. The book does clarify the many practical problems which confront your diabetic patient every day.

Health Activities, by Julia C. Foster ($1.00. *J. B. Lippincott Co., Philadelphia),* is designed to help teachers instruct boys and girls in how to keep well. Do you know what they teach in school nowadays?

Psychological Aspects of Medical Care, by Morton A. Seidenfeld, ($2.00. *Charles C. Thomas, Publishers, Springfield, Ill.),* is a timely lecture by the director of the psychological services of the National Foundation for Infantile Paralysis. Every physician should read it and every intern library should have it.

Vaughn's Primer of Allergy, by J. Harvey Black, M. D. ($3.50. *C. V. Mosby Co., St. Louis, Mo.),* is a guidebook for those who must find their way through the maize of this strange and tantalizing state. I have used the original Vaughn book extensively. Now that Dr. Black has brought it up to date, I shall find it useful for my patients with allergies.

A Manual of Cardiology, by Thomas J. Dry ($5.00. Second edition. *W. B. Saunders Co., Philadelphia),* is a remarkable comprehension of condensation.

Medical Diseases of the Kidney, by J. F. A. McManus, M. D. ($6.00. *Lea & Febiger, Philadelphia),* with 100 illustrations, is an atlas and introduction to the subject. These almost perfect illustrations tell the story of acute and chronic renal failure.

Phenol and Its Derivatives: The Relation Between Their Chemical Constitution and Their Effect on the Organism. National Institutes of Health Bulletin No. 190.

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Mild Hypothyroidism: A Common Disease

HERBERT E. CHRISTMAN, M.D.

EACH week thousands of patients consult physicians complaining of fatigue. A relatively small number are found to have cardiorenal disease, anemia, diabetes, tuberculosis, or Addison's disease as a basis for this complaint. In many instances it becomes evident that life situations are a little too difficult for some of these people to meet. Sometimes the fatigue can be accounted for by poor habits of living, or a schedule of activities which leaves no leisure. Very often, however, no definite diagnosis is made, and the patient is empirically given iron, liver extract, vitamins by mouth and needle, and assorted tonics without benefit; he drifts from one doctor to another, takes vacations as often as his work and pocketbook permit, and finally perhaps reconciles himself to feeling tired.

It has been our impression that many of these people who are tired, but otherwise well, show at least several signs and symptoms of hypothyroidism; laboratory data and response to dessicated thyroid have in most instances been confirmatory. Unfortunately Gull's early description of a cretinoid state in middle-aged women is still the basis of the description of the adult hypothyroid state in some textbooks. Partial hypothyroidism seems to be frequently overlooked, while classical myxedema appears to be growing more uncommon. Because mild hypothyroidism can be so effectively, easily, and inexpensively treated, we present an analysis of 138 cases seen in our private practice. These were found in 1000 consecutive unselected case histories of patients seen in the office during a period of a little less than four years—an incidence of 13.8 per cent in a practice limited to internal medicine but not otherwise restricted.

Submitted January 5, 1950.

The Author

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DIAGNOSTIC CRITERIA

Gull described two women showing languor, increased bulk, round face, smooth fine skin, flattened broad face, depressed nose, soft hair, large thick tongue, gutteral voice, broad spade-like hands, folds of skin beneath eyes and jaws, much subcutaneous fat, slight pretibial edema, and a "mind generally placid and lazy, but liable to being occasionally suddenly ruffled." One also showed menorrhagia and bradycardia. To this picture Ord five years later applied the term myxedema. Since that time dry skin and hair, brittle nails, poor cold tolerance, dyspnea, headache, muscle aches, irritability, impaired fertility, dysmenorrhea, anemia, lowered metabolism and serum iodine, and elevated cholesterol have been described as associated with hypothyroidism, with or without myxedema.

All of our patients have had at least four (usually more) of the clinical signs or symptoms, a lowered basal metabolic rate, an elevated serum cholesterol when this determination was

done, and all showed a definite subjective and objective response to thyroid therapy. Serum precipitable iodine determination, an expensive and difficult procedure, was not done. Curtis found serum iodine depressed after thyroidectomy and roughly proportionate to the basal metabolic rate. Winkler et al[1] found serum iodine low in untreated hypothyroidism, though often greater than zero; with administration of desiccated thyroid it rose faster than the basal metabolic rate in a roughly linear fashion. Unfortunately no method yet devised for serum iodine determination is simple enough to be practicable for routine use; furthermore a fairly large range of error is inherent in the technique.

It is extremely important to distinguish hypometabolism from hypothyroidism, for the former is not benefited by desiccated thyroid. Means points out that many perfectly normal individuals have a low basal metabolic rate, perhaps as a manifestation of increased efficiency; this is also found in Addison's disease, Simmond's disease, starvation, nephrosis, sometimes in diabetes; it is also found at times in undernourished and chronically tired individuals who also have other symptoms suggesting mild hypothyroidism. The serum cholesterol may help to distinguish this group when the differential diagnosis is not obvious; a therapeutic trial for a month will certainly differentiate, for the response of the true hypothyroid is one of the most gratifying responses in medicine and usually a source of amazement to the patient, while the non-hypothyroid patient may tolerate larger doses of thyroid or thyroxin than the normal gland secretes and yet show little or no effect on symptoms, pulse rate, serum iodine, or basal metabolic rate.[2]

In this group of 1000 patients 20 were found to have a low basal metabolic rate but were not hypothyroid. Since these patients all had symptoms suggesting hypothyroidism and since estimation of the basal metabolic rate was not done where symptoms did not suggest its need, it can be assumed that the true incidence of hypometabolism in this group was considerably higher.

AGE AND SEX INCIDENCE

Age ranged from 14 to 71 years, although there were only six older than 60. (The author's practice does not include children before puberty.) Peak incidence was in the fourth decade, with a large number also in the third and fifth. There were 112 females to 26 males, a little lower than the ratio usually reported.

The explanation for this sex discrepancy encourages speculation; menstruation and child-bearing are the obvious points of difference between the sexes which immediately come to mind. It has long been recognized that the basal metabolic rate normally increases throughout the last 6 months of pregnancy, but Sandiford and Wheeler have calculated that this is directly proportional to the increase in body surface of mother and foetus combined. More significant is the recent study of Heinemann et al[3] showing that serum iodine rises as early as the third week, remains throughout pregnancy about 50 per cent higher than in non-pregnant normal subjects, and falls rapidly after delivery. In the only three subjects who had these studies continued as long as three months postpartum, serum iodine fell to less than the normal level for non-pregnant subjects. They also correlated low levels with miscarriage or threatened abortion. Similar studies carried out over a longer period postpartum might give interesting information on incidence of hypothyroidism developing after childbirth. Observations by the same group indicate a slightly lower serum iodine after menstruation than before, although the difference is not great. Apparently there is no difference in serum iodine between normal males and normal non-pregnant females.

In our group there were 79 parous women, 33 nulliparous, and 26 males; these differences are

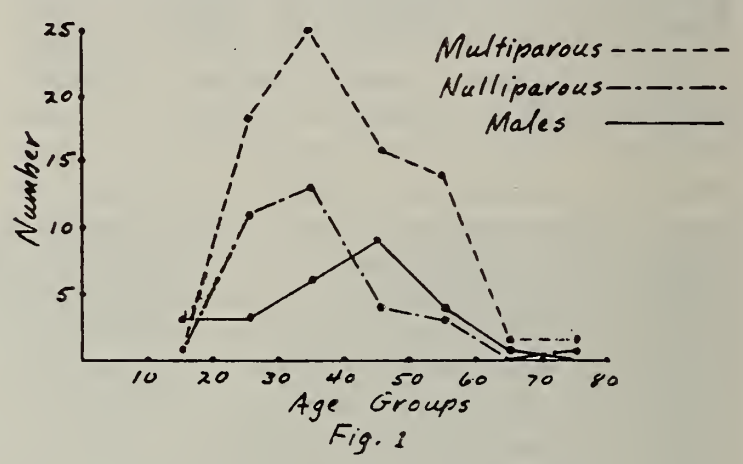


Fig. 1

not explained by the total numbers of these three groups seen. Reference to figure 1 indicates that age incidence by decades is fairly well scattered in our males, while in females, both parous and nulliparous, the highest incidence is in the fourth and third decades, respectively—that is, the child-bearing years. It is also striking that not infrequently the symptoms appeared after a delivery, sometimes the second or third one. In our few cases in the second decade —too few to be significant—no sex difference was noted.

This indirect evidence would suggest that child-bearing and menstruation might both be factors contributing to the higher incidence of hypothyroidism in females.

FATIGUE

Of the 138 hypothyroid patients every one either complained chiefly of easy fatigability or admitted it upon questioning. Of the 1000 patients from whom the 138 were drawn, 325 com-

plained of or admitted fatigue; hence in 41 per cent of all these tired patients, hypothyroidism appeared to cause, and desiccated thyroid relieved, this symptom.

INTEGUMENT

Eighty-five per cent of the 138 showed a dry skin (more often a little rough and scaly than smooth and fine, as Gull described it), dry brittle hair, often falling excessively, or brittle or ridged nails; most of them showed changes in all these structures.

Of the women during the menstrual age, 24 per cent had a vaginal discharge which microscopically consisted of squamous epithelial cells with some leukocytes. This was definitely not a cervical discharge, and all women having cervicitis or vaginitis apparently due to other causes were excluded.

CALORIGENESIS

Poor tolerance for cold was rarely offered as a primary complaint but was admitted on questioning in 80 per cent. These patients felt better in warm weather, liked the house or apartment warmer than the average (usually 75-80°F.), and often complained of cold hands and feet.

CARDIOVASCULAR SYMPTOMS

Dyspnea on one flight of stairs, with no objective evidence of cardiac or respiratory disease and no significant anemia, was present in 24 per cent, palpitation in 12 per cent. These symptoms would tend to direct one's attention first to the heart, lungs, and blood, or might even suggest hyperthyroidism.

Bradycardia has been regarded as one of the common signs of hypothyroidism. In this group 26.8 per cent had a pulse rate below 70, 62.3 per cent between 70 and 80, and 10.9 per cent over 80. These rates, however, were recorded on routine office visits, not under basal conditions. It was felt that determination of range of pulse rates on casual visits would be of more value than under unusual conditions of examination.

Blood pressure was considered low if the systolic pressure was less than 100 millimeters or if the pulse pressure was less than 40 per cent of the diastolic, high if the systolic pressure exceeded 150 or the diastolic 95. Using these criteria, 1.4 per cent were hypertensive, 34.7 per cent normotensive, and 63.9 per cent hypotensive. Almost all of the last group had low pulse pressures.

Because of the hypercholesteremia of uncontrolled hypothyroidism it might be assumed that atherosclerosis would be more common in this group. Barr states that individuals with untreated myxedema ultimately develop arteriosclerosis. Experimentally, Steiner et al have produced in the dog arteriosclerotic lesions showing the same morphology, development, and distribution as human arteriosclerosis by feeding cholesterol and thiouracil; the associated hypercholesteremia is much greater than that produced by cholesterol alone, and atherosclerosis in this omnivorous animal could not be produced by cholesterol alone. Dauber et al found that desiccated thyroid consistently minimized the rise in blood cholesterol and gave some protection against atherosclerosis in cholesterol-fed chickens. Clinical correlation between elevated serum cholesterol and increased incidence of coronary disease has been observed. Of the 15 males in our series past 40, two had had myocardial infarctions at ages 42 and 44; two others showed peripheral and aortic arteriosclerosis in the sixth decade, and one at 60 showed electrocardiographic changes suggesting coronary disease. Although coronary sclerosis is relatively uncommon in women under 60, two of our female patients showed clinical and electrocardiographic evidence of this at 56, as well as two older women. Even apart from all other considerations, this would suggest the importance of treating hypothyroidism adequately.

The term myxedema was first proposed by Ord because he thought the peculiar edema in this disease was due to mucin. Forty-seven years later Boothby et al demonstrated that it is due to protein and water storage because of reduced endogenous protein metabolism. Some degree of patent edema, never striking, was found in 26.5 per cent of this series, chiefly evident in ankles, hands, neck, and face, especially periorbital. It was usually associated with a basal metabolic rate lower than —20, never higher than —15; yet many with a low basal metabolic rate did not show it.

GASTRO-INTESTINAL SYMPTOMS

Constipation was present in 40 patients (29 per cent). Some of these had symptoms of an irritable colon and were given appropriate diet and antispasmodic therapy; many denied these symptoms, and their constipation was corrected with no therapy or advice other than thyroid.

Because of hypercholesteremia one might anticipate an increased incidence of cholelithiasis. This was demonstrated in 11 of our group (8 per cent), an incidence no greater than Bockus estimates for the entire adult population. It is not significant that three of the 138 had peptic ulcer, but it is interesting that two of these were women, despite the relatively low incidence of ulcer in women. Of four female ulcer patients seen in our office practice during the four-year period covered in this study, three were hypothyroid. Bockus states that about 10 per cent of his peptic ulcer patients show a low basal metabolic rate and elevated cholesterol,

roughly the same incidence as in our 1000 unselected cases, most of whom had no ulcer.

SYMPTOMS REFERABLE TO REPRODUCTIVE SYSTEM

Vaginal discharge in hypothyroid women has already been discussed. There was a history of sterile marriages or miscarriages without other known reason in 29 of the 76 married women in the child-bearing period (38.2 per cent). Dysmenorrhea and/or menstrual irregularities (most often hypomenorrhea and/or irregular or lengthened intermenstrual intervals) were found in 68.6 per cent. Failing libido or impotence was noted in 20.8 per cent.

SYMPTOMS REFERABLE TO CENTRAL NERVOUS AND SKELETAL SYSTEMS

Nervousness, depression, or irritability was a complaint in 81 patients (58.7 per cent). Only occasionally was it found necessary to employ small doses of a mild sedative in addition to thyroid.

Headache was complained of or admitted in 58 patients (42 per cent) and almost invariably disappeared with adequate thyroid therapy. It was usually occipital, occurring characteristically at the end of the day or when tired, and was in no way different from the tension headache which many people experience at the end of a hard day. Its frequency in hypothyroidism may be due entirely to the excessive effort these people must expend to carry on their ordinary daily tasks. However, Thompson et al found an increase in spinal fluid protein in myxedema, dropping to normal after thyroid administration. Pressures were not recorded in their paper, although their data indicated that the rate of spinal fluid flow was not increased.

Osteoarthritis was found in six: three were in the fifth decade and three in the sixth. None of this series had rheumatoid arthritis. Eighty others at all ages had joint or muscle pains; some of these thought or had been told that they had arthritis, but there was no objective evidence of it. A common complaint was a peculiar poorly localized aching and stiffness, usually in the legs and back, most troublesome when the patient got out of bed in the morning or out of a chair after sitting for a long time, disappearing after a little activity. This disappeared rather promptly after thyroid therapy; indeed, even those with osteoarthritis of spine and knees usually claimed amelioration of stiffness and pain. Possibly this stiffness may be due to edema in and between the muscle fibers.

GOITRE

Marine has pointed out the association of partial hypothyroidism with simple goitre and finds that partial hypothyroidism can be treated by iodine alone. Winkler expressed the opinion that true hypothyroidism is not associated with colloid goitre, even though the basal metabolic rate may be low. In this series we found six (4.3 per cent of the total) with goitres and associated hypothyroid signs and symptoms, including hypercholesteremia in the two cases where serum cholesterol was estimated. Thyroid improved the symptoms and lowered the cholesterol but did not alter the sizes of the goitres. Three others had had small goitres in their teens, not clinically evident now. Four others had had thyroidectomies, one for a toxic goitre.

ALTERATIONS IN THE BLOOD

Hurxthal has pointed out that hypercholesteremia occurs with myxedema, the blood cholesterol usually bearing a roughly reciprocal relationship to the basal metabolic rate. In our series cholesterol was estimated in 34; in 33 it was elevated, the highest 340 milligrams. There was no relation to body weight.

Several studies[4] have shown that anemia, either hypochromic or macrocytic, may occur with myxedema. Of the 121 patients in this series who had one or more blood counts, 25 had a hypochromic or microcytic anemia, 19 macrocytic. (Standards* used are: males red blood count 5.4 ± 0.8 million, hemoglobin 16 ± 2 grams, hematocrit 47 ± 7; females red blood count 4.8 ± 0.6 million, hemoglobin 14 ± 2 grams, hematocrit 42 ± 5.) In no instance was the red count below 3 million or hemoglobin below 10 grams; liver was never employed, iron only occasionally. Without thyroid both these hematinics have little or no effect. Since achlorhydria and a macrocytic anemia will be found in some hypothyroid individuals, the unwary physician may be trapped into a hasty diagnosis of pernicious anemia; however, the anemia is not megaloblastic, there is no associated glossitis or cord degeneration, and liver extract or vitamin B_{12} are not indicated. We have not seen both diseases in the same individual; the two may of course coöexist.

Three of the 138, all young women, had a mild non-thrombocytopenic purpura, which showed lessened capillary permeability and clinical improvement under thyroid therapy. Obviously such a small number is not significant but suggests that further observation is desirable. Capillary fragility was tested only when easy bruising was observed or complained of; possibly routine testing and progress observations under therapy might show a higher incidence. In myxedema increased capillary permeability has been demonstrated by Lange's fluorescein method.

BASAL METABOLIC RATE AND DOSAGE LEVEL

Athyreosis is associated with a basal metabolic rate of —35 to —45. In myxedema Means and

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* Wintrobe: Hematology, p. 73. Lea & Febiger, Philadelphia, 1946.

Lerman[5] found the curve of response to thyroid to describe a parabola: ½ grain would raise the rate to —20, 1 grain —10, 1½ grains —5, and 3 grains ± 0. Winkler et al,[6] although noting an individual variation in ration independent of the weight and basal metabolic rate and a basal metabolic rate varying in the same patient without changing the dose of thyroid, nevertheless found a roughly quantitative linear relationship between the basal metabolic rate and dosage, which rarely exceeds 3 grains per day. They found that the patient with true myxedema develops no tolerance to thyroid. On the other hand, in subjects with hypometabolism without myxedema, tolerance to desiccated thyroid and in lesser degree even to intravenous thyroxin can be demonstrated, presumed to be due to inactivation by the thyroid gland.[2]

In our series there was only one patient with classical myxedema, possibly because practically all these individuals had sought medical aid before their symptoms had been present for years. Seventy-four had basal metabolic rates between —11 and —20, thirty between —21 and —30, the remainder about equally divided higher than —11 or lower than —30. The propriety of including a few with rates of —6 to —10 may be questioned; they are included because they all showed signs and symptoms of hypothyroidism, all responded within a few weeks to thyroid, and all relapsed when thyroid was discontinued. Two showed hypercholesteremia.

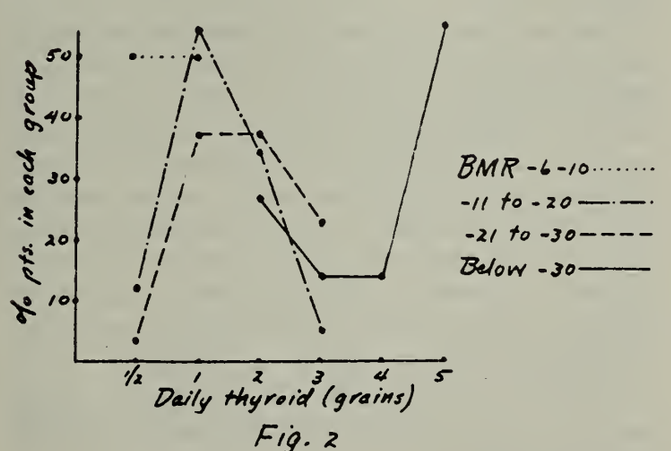


Fig. 2

Figure 2 indicates the spread of thyroid dosage. In the few patients with a basal metabolic rate of —6 to —10, about half received maximum benefit with ½ grain thyroid, the other half 1 grain. Of the large group whose rates ranged from —11 to —20, over half seemed to obtain full therapeutic effect from 1 grain, one-third from 2 grains, a smaller number ½ grain, and a very few from 3 grains. Between —21 and —30, most of the patients seemed to require 1 or 2 grains, a few 3; below —30 over half required 5 grains.

Obviously these dosage figures do not agree with those of Means and Winkler, which applied to the myxedematous patient. If we assume that the thyroid glands of the non-myxedematous hypothyroids were present but functioning inadequately, and if we accept the hypothesis that administered thyroid may be destroyed by the thyroid gland, it would be not unreasonable to picture a gland liberating insufficient hormone and yet with enough functioning tissue to inactivate part of the administered thyroid.

We prefer to start with a small dose, ½ or 1 grain daily; although most of these patients do not show the extreme thyroid sensitivity of true myxedema, figure 2 indicates that these doses are often adequate, and we prefer to avoid overdosage, which may influence the patient against taking thyroid. He is then seen every two or three weeks until symptoms are well controlled. It is not necessary to attain a ± 0 basal metabolic rate. The slowly cumulative effect of desiccated thyroid makes irrational divided daily doses or frequent change of dose.

Although the optimum thyroid ration for a given patient has usually in our experience remained quite constant, occasionally it may vary over a long period of time, and several women whose hypothyroidism first became evident following childbirth have later been able to discontinue or reduce the drug, suggesting in these cases temporary suppression of secretion rather than diffuse alteration of glandular structure. For this reason, after the optimum dosage has been attained, we caution all patients regarding symptoms of overdosage and check them approximately every three months even if no abnormal symptoms appear.

Practically all the aforementioned evidences of hypothyroidism show response within a few weeks of establishment of the correct dose. Blood pressure is a notable exception; the systolic pressure shows little rise, but the pulse pressure increases. Occasionally iron is used as an adjuvant for the hypochromic anemia; usually it is not needed. Thinning hair may not be restored, although patients frequently remark about integumentary improvement. Of course sterility will not be corrected if other causes are present, but several of our patients became pregnant only while taking thyroid. Osteoarthritis obviously does not disappear, although symptoms may be lessened.

DISCUSSION

Means and Lerman[5] hold that "a person either does or does not have myxedema. Borderline or halfway types of hypothyroidism . . . exist either not at all or rarely." Myxedema is produced only when the thyroid is totally removed or atrophic. In the experience of these authors such a state is associated with a basal metabolic rate below —30; between —20 and —30 one usually finds slight symptoms of hypothy-

roidism; above —20 one seldom observes them. Although they recognize that full-blown spontaneous athyreosis requires years to develop, they state that "the period of partial athyreosis is passed in the asymptomatic zone of metabolism."

On the other hand Winkler, recognizing the clinical entity of partial hypothyroidism, states "there is usually a period of months and years in which the patient suffers from an incomplete form of hypothyroidism." He considers myxedema evidence of neglect. Hartsock[7] asserts, "If one looks for the typical picture of myxedema the diagnosis will be missed in 75 per cent of the cases." Other authors also recognize the state of partial hypothyroidism.

We feel that the pattern is sufficiently consistent to make at least a tentative diagnosis of mild hypothyroidism even though the basal metabolic rate is not greatly depressed, provided that at least several of the signs and symptoms are present and the blood cholesterol level elevated. Certainly the therapeutic effect is as striking as that obtained with any replacement therapy, and where treatment has lapsed for several months the relapse is just as evident. It is difficult to picture a simple pharmacodynamic effect of dessicated thyroid, apart from its replacement function, overcoming such diverse symptoms as fatigue, skin changes, headache, dyspnea, menstrual disorders, etc., particularly in view of the demonstrated tolerance to thyroid of many normal individuals.

We prefer not to wait for fully developed myxedema, believing that the level of health of the partial hypothyroid can be improved before athyreosis occurs.

SUMMARY AND CONCLUSIONS

1. Mild hypothyroidism is a common disorder; in this study the incidence was 13.8 per cent of 1000 patients seen in an office practice of internal medicine.

2. Fatigue is the most common symptom; it was present in every instance in this series, and hypothyroidism represented 41 per cent of all instances of fatigue seen.

3. Dry skin and hair, brittle nails, poor cold tolerance, dyspnea, edema, hypotension, early atherosclerosis, constipation, vaginal discharge, sterility, miscarriage, dysmenorrhea, menstrual irregularities, impotence, headache, muscle and joint pains and stiffness, and macrocytic or hypochromic anemia are less common findings. We found no definite relation to pulse rate or weight.

4. Blood cholesterol is consistently elevated.

5. In this series the incidence of postoperative hypothyroidism and simple goitre was small —less than 5 per cent of the total.

6. Incidence is much greater in females, especially in the third and fourth decades.

7. Symptoms, signs, and laboratory abnormalities are corrected by desiccated thyroid, although dose is less predictable and response to thyroid less marked than in true myxedema.

8. Hypometabolism without hypothyroidism must be differentiated.

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The Story Behind the Word

Some Interesting Origins of Medical Terms

Keloid—A descriptive term applied because of the irregular processes or projections occurring at the edges of this cicatrix-like lesion, which in appearance resembles a spreading stain. The name is derived from the Greek word "kelis" or stain.

Malaria—This disease has been known under various names since ancient times. In 1753 Torte published a classical treatise upon the various climatological fevers in which the term malaria was used for the first time. The disease was so named from the erroneous concept that it was caused by foul or bad air from swamps and low-lying areas. The word is of Italian derivation, coming from the words "male," meaning ill or bad and "aira" or air.

Nausea—Literally means seasickness. It is derived from the Greek word "nausia," meaning ship or seasickness and from the Greek term "naus" a ship.

Nightmare—This term has descended to us from the ancient Norse mythology. In this word we remember the old Norse demi-god, Mara, who was said to strangle people in their sleep.

Hysteria or Hysterical—These terms literally signify an attack or seizure provoked through the uterus. The terms are derived via the Latin from the Greek word "hustera," the womb or uterus. As the name indicates the pelvis of hysterical women is their most common physical focus of emotional interest.

—Harry Wain, M. D., Mansfield, Ohio.

Benign Nervousness

LEONARD L. LOVSHIN, M.D.

FUNCTIONAL illness is the most common condition seen in general or clinic practice, but it should not be assumed that all patients with emotional or nervous problems are psychoneurotic. Allan and Kaufman[1] have recently emphasized the inadequacy of traditional neuropsychiatric classification for that large group of patients who have relatively minor functional disease. They have suggested that benign nervousness be recognized as such despite the fact that no suitable diagnostic term is available at present. Since the prognosis in the benign states is so much better and the treatment often so easy and satisfactory, there is much to be gained in trying to separate these from the more serious types of neuropsychiatric disorders—psychoneurosis, psychosis, and psychopathic personality.

The patient with benign nervousness is usually of adequate capabilities and has made satisfactory adjustment. Because of situational factors, usually of a temporary nature, he has developed an emotional reaction which produces one or more symptoms. The history of the present illness is clear-cut, the story is unchanging. He may have presented himself for examination with a considerable degree of reluctance, often at the suggestion of a friend or relative. After a careful examination simple reassurance sometimes is all that is needed to bring about improvement. In some instances the offending situational factors must be corrected. This is occasionally accomplished easily; at other times it is impossible. The patient is often benefited by discussing his problems with a sympathetic listener. Simple sedatives may be of help in the readjustment period. The patient is usually pleased and gratified to learn that no serious illness is present. Insight may be very good; indeed, many patients sense the cause of their trouble even before being told.

The true psychoneurotic, on the other hand, has an inherent defect in his personality; the trouble is from within. There is usually a long history of maladjustment, a train of vague illnesses and often repeated operations or other treatments. The medical history may be complicated and inconstant; sometimes considerable resistance is encountered. Upon being told that no serious illness is present the reaction is often one of disbelief or actual hostility. Simple reassurance is a disappointing therapeutic measure.

From the Cleveland Clinic and the Frank E. Bunts Educational Institute.

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FAMILIAR PROBLEMS TO PRACTITIONER

Every practitioner is familiar with the problem presented by the overworked businessman or the tired mother. Diagnosis is not difficult but codification of nomenclature is a problem not yet solved. It is not only incorrect, but grossly unjust to be required to classify a tired mother into one of the six types of psychoneurosis—hysteria, psychasthenia, hypochondriasis, anxiety state, neurasthenia, reactive depression, or mixed. As a matter of fact, most of these mothers are not psychoneurotic at all, they are just tired. Nor is the overworked businessman psychoneurotic; he may be tired and irritable, and be bothered with dyspepsia but he has been stable in the past and after his vacation will be again.

NO SUITABLE DIAGNOSTIC TERM

There is probably no one term which can be used to describe all types of benign nervousness just as no one designation is satisfactory for all types of psychoneuroses or psychoses. Chronic nervous exhaustion is a useful term which carries with it little of the stigma commonly attached to the use of the word psychoneurosis. Nervous fatigue denotes a lesser degree of nervous exhaustion. Situational reaction used not in the sense of reactive depression but, as was found useful in the past war, to denote an essentially stable individual reacting to unusual external stress, may impart a more exact nuance of meaning. Anxiety state or anxiety-tension state in many instances is as applicable to the benign conditions as it is to psychoneuroses. Diagnostic terms which refer more specifically to the system or area of the body most obviously involved, like irritable colon or tension headache, are commonly used. There should be no great objection to the use of these diagnoses as long as it is clearly understood that they are but manifestations of the underlying nervous or emotional upset.

MAJORITY AFFECTED AT SOME TIME

Benign nervousness is a condition which affects almost everyone at some time or other. No class of society is exempt. The complexity

of modern civilization and the stress and conflict engendered by the frequent disparity between ambition and attainment are factors which beset the majority. Somatic manifestations of simple nervousness may be exceedingly mild—irritability, or a loose bowel movement before breakfast; nevertheless they vary only in degree from those reactions which assume clinical importance. It is not to be inferred that there is any sharp line of distinction between the more severe benign reactions and the true psychoneuroses. However, it is of considerable practical importance to recognize those reactions which represent no true deviation from what might be expected of the hypothetical average man.

SITUATIONAL FACTORS FREQUENTLY ARE CONTRIBUTING CAUSES

Despite the widespread incidence of benign nervousness there are certain occupations and situations which are particularly inclined to foster an increased incidence of this disorder. Only a few of these will be mentioned.

The tired mother syndrome is well known to most physicians. In its most common form an intelligent, tense, overconscientious young mother begins to feel run-down and tired. She becomes nervous and irritable and may develop any of a large number of symptoms which tend to worry and confuse her further. No psychoanalysis or deep probing is needed to understand the situation. Her work-day is sixteen hours; she works seven days a week. She probably has not had a vacation in years except for the brief time allotted for convalescence after childbirth. There often are worries about finances or ill health of the children. A careful physical examination, reassurance, and sympathetic advice often is all the treatment needed. Any physician who by chance or circumstance has had the responsibility of running his own household for even a short period of time has probably learned why mothers are apt to develop nervous fatigue.

The two-job wife is in another group from which is recruited a large number of benign nervous reactions. The average male is expected to work eight hours a day. He is not expected to cook meals, wash dishes, and do housework after his day is over. Many women handle these double responsibilities capably, especially when there are no children. Indeed, in many instances, when the household tasks are light, a job in business or industry contributes to the welfare of the otherwise idle wife. However, many women who must work because of financial necessity find the double burden too great. It is not surprising that a number of them become overtired and nervous.

Lest it be assumed that benign nervousness belongs exclusively to the female, it would be well to mention that the overworked business executive is a common victim. He is often possessed of great energy, ambition, and drive. He is not well-acquainted with ill health. For years he may work too hard, play too hard, and break most rules of physiologic living. His energy seems inexhaustible and he squanders it lavishly. There is apt to come a time, however, when he can no longer do one and one-half days' work in one day and he becomes concerned because of the ebb in vitality. Somatic symptoms may finally force him reluctantly to seek medical advice. Dealing with a patient of this group is usually a gratifying experience for the doctor. Reassurance, simple advice, and a vacation, work wonders. The patient soon feels well, thanks his medical adviser, and goes back to working too hard again.

The small businessman is also especially apt to develop benign nervous conditions. The incidence often varies with the type of business. Restaurant and tavern owners are frequently seen by the physician because of functional disease; more specifically, owners of small restaurants and taverns. In a relatively small establishment the proprietor tends to spend most of his waking hours at his place of business. There are laws to protect the employees, but the owner-manager works on. Meals are irregular and hurriedly eaten; there is a tendency to smoke and drink too much. It is not hard to understand why dyspepsia is the symptom most commonly complained of. When the family living quarters are directly adjacent to, or above the place of business, the ratio of nervous disorder increases. Owners of small grocery stores and filling stations work under similar conditions and are similarly afflicted.

ASSOCIATE OF ORGANIC ILLNESS

Benign nervousness is a common accompaniment of organic illness. Indeed, it is axiomatic that every disease has an emotional component. This fact is known and understood by all, but the relative importance of each factor in the production of symptoms is often not clearly evaluated. The emotional symptoms occasioned by the discovery of an early carcinoma of the breast in an essentially happy and stable woman will disappear with successful surgical treatment of the breast lesion. Cholecystectomy in a tired, unhappy woman with many family worries can only be expected to relieve the gallbladder colic for which the operation was performed. Too often an unimportant organic finding is used to explain unassociated functional symptoms. The iatrogenic disability due to injudicious emphasis is well demonstrated in many patients with mild chronic valvular heart disease.

It should be recognized that organic illness may be the precipitating cause of emotional illness in some cases; in many, the organic illness is a contributory cause; and in a large

number of patients organic findings are purely coincidental.

It is believed that more harm than good results from applying even an innocuous organic label to illness which is purely functional in origin. Too often a chronic nervous exhaustion state, as a matter of convenience, is called anemia, hypotension or hypothyroidism. The mere fact that nervous fatigue responds so well to anti-anemic therapy is ample proof that many of the benign nervous states are self-limiting illnesses. Most patients appreciate being told that no organic disease is present. Insight is remarkably good in many cases.

DUTY OF GENERAL PRACTITIONER

The general practitioner is well qualified to diagnose and treat benign nervous conditions; in fact, he has done so since the dawn of medical history. Not only is he well qualified, but the nature of his practice and his thorough acquaintance with the patient, his family, and the community make him better qualified than any specialist. As a general rule psychiatrists cannot and should not be expected to take care of these minor emotional and nervous upsets. It is the general practitioner's duty, however, to be able to separate the benign from the more serious functional disorders, and apply for special help when it is needed.

Treatment is usually satisfactory although sometimes the situational factors are such that only limited help can be given. In a large number of cases the factors responsible for the illness are almost self-evident and no psychoanalytic probing is necessary. Explanation and reassurance are the most valuable therapeutic measures. The patient should be encouraged to correct those environmental factors which are remedial. Simple sedatives are sometimes helpful during the transition period. There is, however, no medication that can take the place of forthright reassurance based on the confidence acquired from a careful and thorough physical examination.

CONCLUSIONS

Minor emotional and nervous disorders are the most common conditions seen in the general practice of medicine. Not all nervous people are psychoneurotic. Despite the inadequacy of traditional neuropsychiatric classification, an attempt should be made to recognize the benign nervous disorders. The general practitioner is best qualified to diagnose and treat these conditions. Treatment is usually satisfactory and should be based on reassurance, explanation, and sympathetic understanding. The use of diagnostic terms implying organic alteration is to be avoided.

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APHORISMS, ADAGES AND MAXIMS

The experience and wisdom of the sages are preserved by maxims and sayings.

Coleridge said, "The largest and worthiest portion of our knowledge consists of aphorisms, adages, and maxims."

I am convinced the following gems, if made our own, will become a part of our lives, and an influence on our careers.

"EVERY thought has a physical reaction."

"TIREDNESS and weariness without cause indicate disease."

"WAR wounds men's minds as much as it maims their bodies."

"OUR disposition is closely related to our digestion."

"To lengthen your life shorten the meals."

"A DISEASE germ is not too proud to inhabit a youngster wearing an asafetida bag."

"EACH one of us is an omnibus loaded full of our ancestors."

"HE who won't be advised, can't be helped."

"A MERRY heart doeth good like a medicine; but a broken spirit drieth the bones."

"NATURE is the ally of the patient and the enemy of disease."

"IT is a part of the cure to wish to be cured."

"No man is so old but thinks he may live another day."

"FOLKS with something on their conscience can't sleep."

"WE go out of life unconsciously as we come into it."

"NEVER buy a pig in a poke."

"CASTOR oil makes its own way."

"THE non-vaccinated can be no real menace to the vaccinated."

"BETTER be rudely healthy than pale and interesting."

"NIGHT air is as safe to breathe as day air."

"No man's opinion is entirely worthless, even a watch that won't run is right twice a day."

"NEURASTHENICS are more often all 'wound up' than 'run down.'"

"AN ounce of prevention is worth a ton of cure.

"LIVE with youth and you stay young; keep up with youth and you die young."

"PAST pains and pains to come seem never as bad as present pains."

"MEMORY for past events becomes dominant as one grows older."

"A HEALTHY liver makes a good disposition."

"MANY dogs will kill a rabbit, many defects will kill a man."

"THE cure of tuberculosis depends more upon what the patient has in his head than on what he has in his chest."

—Submitted August 15, 1950,
John J. Sutter, M. D., Lima, Ohio.

Leiomyoma of the Esophagus: Report of a Case With Successful Resection

WALLACE C. MADDEN, M. D., and EDWIN G. OLMSTEAD, M. D.

BENIGN tumors of the esophagus are rare; however, in the past fifteen years an increasing number of these tumors have been diagnosed correctly and successfully removed. As these tumors offer a uniformly good prognosis it is important to differentiate them, both clinically and by X-ray examination, from the more common malignant tumors of the esophagus.

Some idea of the rarity of these tumors may be gathered from Moersch and Harrington's report[1] that of 11,000 patients complaining of dysphagia only 15 had benign tumors of the esophagus as a basis of the complaint. That all benign tumors of the esophagus do not give rise to symptoms may be seen in the same report in which of 7,459 autopsied cases, 44 had benign tumors of the esophagus which had not caused symptoms during life.

Benign neoplasms of the esophagus include adenoma, aberrant thyroid, cysts, fibroma, leiomyoma, lipoma, myoma, myxofibroma, papilloma, and polyps. Of these, the leiomyoma is the most common. At postmortem small leiomyomata of the esophagus are frequently found, but they must attain considerable size before they become large enough to produce symptoms.

These tumors occur most frequently at the upper or lower one-third of the esophagus with a small number occurring in the middle one-third. They are more common in men than in women and are usually seen after the age of forty although they may be encountered in any age group.

CASE REPORT

A twenty-eight-year old white male was admitted to the Miami Valley Hospital March 25, 1949, complaining of cough of three years' duration, pain in the chest for two years, and shortness of breath for three weeks. He stated that he had been in good health until three years before admission at which time he caught cold and developed a cough which had continued until the present time. The cough was productive of whitish sputum and was worse when the patient was lying down. The sputum had been blood-streaked on two occasions, one month before admission. Two years before admission the patient experienced a sharp non-radiating substernal pain which at first was intermittent, but later became a constant dull ache, made worse on coughing. Three weeks prior to admission he noticed shortness of breath on walking a few blocks or climbing steps. He had lost twenty pounds in the last two years. On system review he admitted that he "filled up" easily after eating even a small amount of food.

Physical examination revealed a well-developed, well-nourished white male who did not appear acutely or chronically ill. Examination of the head and neck was essentially negative. The chest was clear to percussion and auscultation. The heart was normal in size and heart beat was regular at eighty per minute. The blood pressure

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Fig. 1—Barium swal'ow outlining tumor of mediastinum. Note dilatation of the esophagus above area of constriction. Note "shelf" of barium at "a" where tumor meets uninvolved portion of esophagus.

was 124/88. Examination of the abdomen and extremities was not remarkable. The red blood count was 4,480,000 per cubic millimeter, with 94 per cent hemoglobin. The white cell count was 11,000 per cubic millimeter with a normal differential. Urinalysis was normal.

A teleoroentgenogram of the chest showed enlargement of the superior mediastinum more marked on the right than on the left. The aortic knob could be visualized on the left and the cardiac silhouette was normal in size, contour, and position. The lung fields were normal.

A barium swallow (figure 1) showed a roughly oval, fairly well circumscribed soft tissue mass in the left superior mediastinum which displaced the esophagus to the right and sharply compressed the esophageal lumen at the level of T6. A sharply defined lower border or shelf of barium could be seen where the tumor met the esophageal wall. The esophagus was dilated about four times its normal diameter above the area of compression and contained particles of food debris. A lateral film of the chest following barium swallow showed the esophagus displaced and compressed posteriorly and the trachea displaced anteriorly. There was no evidence of involvement of the esophageal mucosa.

Esophagoscopy was performed and demonstrated a narrowing at the junction of the upper with the middle one-third of the esophagus due to some external pressure in this region. The esophagoscope was easily passed beyond the point of narrowing and the esophageal mucosa was reported as intact throughout.

The patient was prepared for surgery.* He was draped with the right side up and the incision was made over the fifth rib. The muscles were transected and the fifth rib removed. The pleura was opened and the lung was retracted downward and forward visualizing a fairly large tumor in the upper posterior mediastinum in the region of the esophagus. Further exploration revealed this to be intrinsic with the esophageal musculature. The esophageal musculature was divided and the tumor was shelled out with ease. The mediastinal pleura was closed with continuous chromic No. 000. The wound was thoroughly washed with aqueous Zephiran.® Closure was made in the usual manner. The patient made an uneventful recovery and left the hospital on the eleventh postoperative day. Subsequently all symptoms disappeared. The patient feels well and at present is employed in a moderately active occupation.

DISCUSSION

The clinical features of leiomyomata of the esophagus are similar to those seen in any submucosal intramural benign tumor of this region. It should be noted that these tumors reach a large size before producing symptoms and so are occasionally encountered on routine chest plates at a time when the patient may have no symptoms referable to the esophagus.

Dysphagia is probably the commonest symptom reported in benign esophageal lesions. It is often intermittent in character. Regurgitation of food may be present and depends on the degree the tumor has encroached upon the esophageal lumen. There is often a sense of substernal discomfort made worse when the patient is recumbent. Dyspnea, cough, and expectoration are present in varying degrees. In general, the physical condition of the patient remains remarkably good in spite of the complaints, and weight loss, anemia, and other constitutional findings occur but rarely in these patients, a fact which is in distinct contrast to the findings produced by malignant tumors of the esophagus.

Although the duration of symptoms may be longer in benign tumors as opposed to malignant tumors of this region, the symptoms themselves are often so similar that differentiation on clinical grounds alone may be very difficult. However, the combination of the above symptoms together with a posterior mediastinal mass should certainly raise the question of a benign tumor of the esophagus.

Patterson[2] was of the opinion that there was no means of making a diagnosis of benign tumor of the esophagus except by esophagoscopy or, in the case of mucosal tumors, unless the tumor was regurgitated through the mouth. However, primarily through the work of Schatzki and Hawes[3] the roentgenological appearance of these tumors has been elucidated. Submucosal intramural benign tumors usually show a fairly well circumscribed soft tissue mass lying outside of the esophagus. This mass may move with swallowing, respiration, or peristalsis. During barium swallow the mucosal folds over the tumor are usually not seen as they are stretched over the tumor mass. The mucosal folds opposite the tumor appear normal. In these benign tumors, in contrast to malignant tumors, there is usually not much impairment to the flow of barium as the opposite wall is normal and dilates to allow barium passage. Probably the outstanding roentgenological characteristic and the one best demonstrated in the above case is the sharp angle formed where the tumor meets the uninvolved portion of the esophagus. This is seen best in profile view and serves to differentiate intramural esophageal tumors from mediastinal tumors making pressure on the esophageal wall in which the angle of the tumor with the esophagus is not usually sharp but gentle and concave.

SUMMARY

1. A case of leiomyoma of the esophagus with successful resection is reported.

2. Some of the clinical and X-ray features of benign intramural tumors of the esophagus are discussed.

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* Surgery performed by Dr. A. J. Carlson and Dr. E. F. Damstra of Dayton, Ohio.

A Plan of Annual Examination for Men

RALPH M. WATKINS, M. D.

APART of our attempts in medical education of the laity includes the advice that people be regularly examined in the effort to forestall disability from disease. The years spent in urging this are gradually bearing fruit, in that larger numbers of persons are asking that they be notified at regular intervals that they are due for examination. Most of the applicants are men. Women seem less inclined to seek periodic surveys. On the other hand, women are more likely to call for medical attention for minor disturbances.

We should like to describe a plan we have followed for several years. It has proven satisfactory both to the patient and to us. This is an office annual examination routine designed for business and professional men over 50 years of age—busy people and assumed to be well, or at least well enough to do their usual work. It has been followed with some scores of men, and has been well accepted. We feel that the plan is simple yet elaborate enough to enable us to detect in the early stages most of the ailments to which this group is susceptible. These men are anxious to learn that the examiner finds no evidence of certain diseases especially those so widely publicized. They most commonly want to know that there is no sign of heart disease, arterial hypertension, cancer or diabetes.

THE PLAN

This plan includes:

- Complete physical examination
- Complete blood count
- Chemical and microscopic urinalysis
- Blood Kline test for new patients
- X-ray examination including fluoroscopy of the chest, stomach and duodenum plus the usual plates of the latter
- Electrocardiogram
- Three pre-prandial blood and urine sugar tests

OBJECTIVES

Obviously, our object is to find pathological conditions, especially to detect them early in their development. The complete physical examination clears up many questions relative to disturbances of the ears, nose, throat, vision, eye grounds, mouth, teeth, lymphatic glands, thyroid gland, lungs, heart, blood pressure, abdominal contents, genitals, prostate gland, anal and lower rectal region, superficial reflexes, skin, bones, joints. Weight abnormalities and changes are recorded.

The complete blood count will show the presence or absence of anemia, infectious reactions, leukemic states and others that can be diagnosed by finding abnormalities of the cells.

The chemical and microscopic urine examination will reveal grossly abnormal kidney function and evidence of infection in the urinary tract. Sugar present means that diabetes mellitus must be ruled out. Erythrocytes seen call for special examination.

The blood Kline test is done, as a rule, on new patients only. If he does not already have it, there is little likelihood of a man in this age group contracting syphilis. If any evidence arises in later examinations, the Kline test is repeated.

The electrocardiogram in a number of instances has proven its value by showing early or mild changes, especially of the coronary system, which had not been suspected from the history or physical findings.

The X-ray examination includes fluoroscopy of the chest which helps to some extent to free the lungs and bronchial tree from suspicion. If any indication of heart or lung disease is found by physical examination, the electrocardiogram or fluoroscopy, plates of the lungs or heart or both are essential.

The primary object of the X-ray examinations of the stomach and duodenum is to do all possible to rule out early gastric carcinoma. The reasons are three: A. This organ is one of the most frequent sites of cancer, especially in men over fifty years. B. As a rule, the early symptoms of it are so mild that by the time the patient is suffering enough to ask medical attention, the lesion is beyond the operable stage. C. The only reasonably simple way of discovering a carcinomatous lesion while it is still fairly small, and perhaps operable, is by X-ray examination. We grant that routine gastroscopy may

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be advisable but we also know that most men will not submit to it as a routine test.

The pre-prandial blood and urine glucose tests are done primarily to rule out the presence of diabetes. Not infrequently, in otherwise normal patients, slightly elevated figures may be reported, suggesting the so-called prediabetic phase. We often discover in this way men who did not know they might easily become diabetics, or, in fact, had the disease in mild degree. Glucose tolerance tests are done occasionally, but only for special reasons.

THE ROUTINE

The complete plan can be carried out in a few hours. The preliminary physical examination, blood and urine examinations, are done at an appointed time and require an hour. The special tests are nearly all done in one morning, as follows: The patient, in a fasting state, enters the office at 8:30 o'clock and the first blood and urine specimens are taken; he is then escorted to the X-ray office, near at hand, and those examinations are started and completed as a rule well before noon; then he returns to our office where his electrocardiographic tracings and second sugar specimens are taken; this work is finished, as far as the man is concerned, by noon and he is then dismissed, told to eat a hearty lunch and to come back to the office at 5:00 p. m. for his final sugar tests. Thus he is free to work during the afternoon and has used only about a half day's time. At his last appearance, an appointment some days later is made, when he is to come in for a full report. Reports are made both verbally and in writing; many of these orderly people seem to appreciate a written record.

OTHER EXAMINATIONS

Additional laboratory tests or examinations by specialists are often found to be needed and are carried out. They naturally are not included in the basic plan we are following.

INTERVAL BETWEEN EXAMINATIONS

The word "annual" is carried in our title. That is the interval which we follow. One grants that yearly intervals are too great, that many diseases can become well advanced between examinations. Perhaps intervals of six months or three months would be better. The fact is, in our experience, that these men are not willing to come for this purpose more than once a year. We must recall that we expect to find them well, and ordinarily do. If disease is found they come in for attention at whatever times are appropriate.

They are all regular patients so if any intercurrent symptoms arise, they are expected to report them, without thought of waiting for their year to elapse.

ADVANTAGES OF THIS PLAN

1. The knowledge gained by this method is more than reasonably adequate. We grant that the program is not complete. Other tests and special studies could be done, and are done if findings warrant. But if the patient can pass the physical examination and if the laboratory results are normal, we feel we can assure him that he has none of the usual diseases—degenerative, malignant, infectious; that his outlook for healthful living is good.

2. A valuable help to us is the frequency of the interview. Too many people call for medical attention only when ill. In seeing each of the men of this series annually we get well acquainted with any abnormality he may have. If later he becomes ill, we do not have a sensation of strangeness in attending him, nor the feeling of the need to start his study at the very beginning.

3. The cost of the complete program is not very great; it is not much larger than it would be if conducted in a hospital with the need for medical supervision and the longer period of time required.

4. For the patient, the great advantage is the little time needed from his work. It is much easier for these busy people to spend a half day with us than to set aside some days for an adequate appraisal in a hospital. It should be remembered that these patients consider themselves well, or at least actively able to work. They wish to be reassured that they are likely to be able to continue their pace.

SUMMARY

1. A plan for annual examinations for men over fifty includes complete physical examination, complete blood count, chemical and microscopic urinalysis, blood Kline test (new patients), electrocardiogram, X-ray of the stomach and duodenum, fluoroscopy of the chest, and three pre-prandial blood sugar tests.

2. The program will reveal any of the common ailments, especially those to which this group is subject.

3. The routine is explained.

4. A year between examinations may not be the proper interval but seems to be the most practicable.

5. The advantages of the plan include: (a) reasonably complete appraisal, (b) close acquaintance with each patient and his peculiar problems, (c) moderate cost, (d) great saving of the patient's time.

The headache of hypertension is caused by pain, fairly diffuse, or it may be focal, present on arising each morning. It is usually throbbing. It may wake the patient up or he may awake with it. It is relieved by aspirin.—Francis M. Walsh, M. D., J. Lancet.

Uterine Fibroids as a Cause for Postmenopausal Bleeding

CHARLES H. HENDRICKS, M. D.

ALTHOUGH an estimated 20 per cent of females past the age of 35 harbor uterine myomata,[1] it is generally conceded that relatively few such tumors actually cause symptoms. Those which produce symptoms do so, for the most part, during the years of menstrual activity, inasmuch as myomas arise after puberty and complete active growth during the period of ovarian activity. After the menopause, uterine bleeding resulting directly from the presence of uterine myomas is relatively rare. Davis[2] states that "women with fibroids do not cease bleeding at this age (i. e., menopause) and then resume bleeding from fibroids." Te Linde[3] studied 349 cases of postmenopausal bleeding, and in only about 4 per cent were myomas felt to be a possible explanation of the bleeding. Taylor,[4] reporting an even larger series, found that even when fibroids were present in the postmenopausal bleeding patient, another concurrent lesion could be demonstrated as the cause of bleeding in the vast majority of cases. Zeit[5] reported recently that of 13 postmenopausal patients in his series who were operated upon solely for myomas, the bleeding was not due to myomas in 61.5 per cent.

A high incidence of malignancy among patients with postmenopausal bleeding is a well-established fact. Te Linde found 53.3 per cent malignancies in his group, while Taylor noted a 63.3 per cent incidence of malignancy in the series which he presented. It becomes apparent, then, that it is unwarranted to assume myoma as the primary cause of postmenopausal bleeding because, while myomas may be present incidentally in a large number of women, they are not usually the site of the significant pathology.

To demonstrate that the problem is more than a hypothetical one, nine cases are presented. Seven are postmenopausal, and the other two were near menopausal age. In each, the patient was treated by one or more of the following: X-ray, radium, supracervical hysterectomy, total hysterectomy, laparotomy, or injections. While treatment was being directed specifically toward the patients' confirmed or imagined myomas, the actually important diagnoses were, respectively, carcinoma of the cervix (5 cases), carcinoma of the corpus (3 cases), and carcinoma of the ovary (1 case). These cases are summarized in table 1.

CASE SUMMARIES

Case 1. The patient was a 54-year old para I, four years postmenopausal. Soon after the onset of severe vaginal bleeding, she consulted a physician who did subtotal hysterectomy for "fibroids." The pathologist's report describes large myomata. A cervical specimen for biopsy was not taken until 7 months postoperatively: it showed squamous cell carcinoma of the cervix.

Case 2. The patient was a 60-year old para VII, who was 5 years postmenopausal. After six months of recurrent bleeding she consulted her physician who, without doing a pelvic examination, diagnosed "fibroids" and treated the patient by "shots" for over a year. A second physician whom the patient consulted found a cervical lesion, which proved to be squamous cell carcinoma of the cervix. No myomata could be demonstrated.

Case 3. A 47-year old para V, five years postmenopausal, had been treated for several years for "uterine fibroid" by conservative therapy. Examination at the Gynecology Tumor Clinic at Ohio State University Hospital revealed far advanced cervical carcinoma. No myomas could be palpated.

Case 4. A 67-year old nullipara, 19 years postmenopausal, had been treated for a Clinical Stage III carcinoma of the cervix by radium and X-ray in 1944. In 1946 she rather suddenly developed a pyometra, and was admitted to another hospital with a diagnosis of "degenerating fibroids." Subtotal hysterectomy was done, and the uterine tissue revealed generalized carcinomatous infiltration of the fundus with squamous cell carcinoma. No myomata were found.

Case 5. This patient was a 41-year old para II, who had not reached menopause, but who had progressively increasing hypermenorrhea for four months before going to her physician who made a diagnosis of "uterine fibroid," and treated the patient successively with external X-ray, supracervical hysterectomy, and another exploratory laparotomy before a speculum examination done elsewhere revealed a cervical carcinoma from which the patient had been bleeding. It cannot be determined whether myomata were actually present in the subtotally removed uterus.

Case 6. The patient was a 62-year old para III, who was 12 years postmenopausal, and who, after several months of vaginal hemorrhages was told by her physician that she had myomas. Intracavitary radium was administered. No biopsy or curettage was done. Bleeding recurred a year later; the patient consulted the Gynecology Tumor Clinic, where diagnostic

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	Patient	Age	Yrs. Post-menopaus.	Original Diagnosis	Treatment Given	Actual Diagnosis	Fibroids Present?
1.	(GM)	54	4	Fibroid	Subtotal hysterectomy	Carcinoma cervix	Yes
2.	(AE)	60	5	Fibroid	"Shots"	Carcinoma cervix	No
3.	(GP)	47	5	Fibroid	Conservative therapy	Carcinoma cervix	No
4.	(NO)	67	19	Degenerating fibroid	Subtotal hysterect.	Carcinoma cervix	No
5.	(RD)	41	0	Fibroid	X-ray, Subtotal hysterectomy, Laparotomy	Carcinoma cervix	??
6.	(CM)	62	12	Fibroid	Radium	Carcinoma fundus	Yes
7.	(HH)	55	1	Submucous fibroid	D & C, Subtotal hysterectomy	Carcinoma fundus	??
8.	(MW)	59	14	Fibroid	Subtotal hysterectomy	Carcinoma fundus	Yes
9.	(FG)	45	0	Menopause & fibroids	Laparotomy	Carcinoma ovary	Yes

Table 1

curettings confirmed the diagnosis of adenocarcinoma of the endometrium. Multiple myomata were found at the time of the subsequent post-radium hysterectomy.

Case 7. The patient was a 55-year old nullipara, one year postmenopausal. Because of intermittent vaginal bleeding, she had cervical polypectomy, dilatation and curettage; the pathology specimen showed no malignancy. She continued to "spot," and two years later, after a tentative diagnosis of "probably submucous fibroids as a basis for the bleeding," had a subtotal hysterectomy which had been immediately preceded by a routine dilatation and curettage. The curettings and excised corpus showed adenocarcinoma of the endometrium.

Case 8. A 59-year old para I, fourteen years postmenopausal, had a pelvic examination because of a bloody vaginal discharge of one-year duration. Subtotal hysterectomy was done for "fibroid uterus"; the pathologist reported multiple myomata and also adenocarcinoma of the endometrium.

Case 9. The patient was a 45-year old para II in the menopause who sought examination for increased vaginal bleeding. She was told that "menopause and fibroids" were causing the bleeding, and was treated by laparotomy, at which time carcinoma of the right ovary was found as well as uterine fibroids.

DISCUSSION

None of the patients mentioned received optimum therapy. Perhaps the outstanding factor preventing such optimum treatment for these patients was the misconception as to the relative importance of myomas as causative agents in postmenopausal bleeding. That fibroids of the uterus fairly frequently cause hypermenorrhea in the years just preceding and during the menopause cannot be disputed. The now established fact that postmenopausal bleeding is very seldom *per se* the result of myoma should become an equally well-known guiding principle in management of these women.

The writer believes that loose usage of the term menopausal bleeding has contributed largely to misunderstandings on this subject. In popular medical jargon, the term menopausal bleeding may too often indicate any excessive or intermenstrual bleeding occurring 10 years before, during, or 10 years after the menopause. Physiologically speaking, the menopause is a *range of time* during which there is a gradual diminution of ovarian function. During this physiologic range of time, patients may not only fall heir to bleeding from any reproductive tract lesion—benign or malignant—which younger women develop, but there is also a vastly increased incidence of so-called functional bleeding, apparently due in whole or in part to ovarian failure, and often associated with endometrial hyperplasia. The combined incidence of these causes of bleeding, together with the rather low aggregate incidence of malignancy, have understandably caused physician and layman alike to regard menopausal bleeding more as a source of annoyance than as a sign of possible malignancy. The real importance of diagnosis in menopausal bleeding, of course, cannot be overstressed.

Bleeding in any patient who appears to have passed fairly well through the menopause, however, should correctly be designated postmenopausal bleeding, and treated with even more respect than menopausal bleeding itself. Here is a select population group in whom any vaginal bleeding indicates malignancy in 50 to 60 per cent of cases. Early, accurate diagnosis, followed by vigorous treatment is indicated in 100 per cent of these cases. Diagnosis is simple in the vast majority of instances, and consists in:

(a) Making certain that the patient is not having withdrawal bleeding following ill-advised estrogen medication;

(b) doing a conscientious pelvic examination, with critical inspection of external genitalia, vagina, and cervix;

(c) taking a biopsy specimen of any bleeding or otherwise suspicious lesion thus visualized;

(d) a thorough dilatation and curettage of

the uterine cavity, followed by submission of the specimen obtained for the pathologist's diagnosis.

In the few patients in whom these steps fail to establish a definite diagnosis, laparotomy may be indicated to rule out the possibility of a functional ovarian tumor.

At pelvic examination, any one of a number of benign lesions causing postmenopausal bleeding may be searched for visually: atrophic vulvitis or vaginitis, ulceration due to the wearing of a pessary, recently broken vaginal adhesions, ulceration of a prolapsed cervix, or cervical or endometrial polyp. Primary malignant or metastatic lesions which have appeared in the vulva, vagina, or cervix can be visualized, as well as endometrial or endocervical carcinoma which has grown out the external os. It should be borne in mind that polyps, while ordinarily benign, may be or may become malignant.

The curet is an invaluable diagnostic aid in cases where the diagnosis is not readily apparent upon speculum examination of the vagina and cervix. Benign lesions may include endocervical or endometrial polyps, submucous or pedunculated myomata or endometrial hyperplasia. The latter is an especially pertinent finding, since it may indicate previous estrogen therapy, an ovarian tumor, or be truly idiopathic in its origin. Carcinoma of the endometrium, sarcoma arising in myoma or uterine wall, and metastic growths are the possible malignant diagnoses established by curettment.

In the previously presented cases, this approach would have made diagnosis certain in the five patients with carcinoma of the cervix, probable in the three cases of carcinoma of the corpus, and possible in the carcinoma of the ovary. Instead, these cases were treated by three general methods, all equally radical: Irradiation, surgery, and neglect. Their treatment failed because it was neither founded upon accurate diagnosis nor carried out with an understanding of the true significance of myomata in the postmenopausal patient.

SUMMARY

Properly speaking, the diagnosis of "postmenopausal bleeding due to myoma" is a *diagnosis of exclusion* because, while many women harbor myomas in the postmenopausal years, they are rarely symptomatic, and the actual cause of the bleeding will usually be found to lie elsewhere. This diagnosis of exclusion should be made only after a painstaking, systematic attempt to establish a more tenable diagnosis. It is obviously important to rule out minor, benign causes of the bleeding so that one will not overtreat the lesion. It is all-important to rule out the presence of malignancy so that one will not undertreat the patient. Nine cases are presented in which inadequate treatment resulted from violation of these principles.

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Pedunculated Lipoma: Case Report

Although pedunculated lipomata are not rare lesions, the subject case involved such a confusing history and the tumor's location was so unusual, that a report is presented.

A 45-year old white man was examined on December 20, 1949. The lesion about which he complained was a soft pendulous tumor hanging from his right axilla. The patient insisted that a tumor the size of a guinea egg appeared in his right axilla within one hour after being



Fig. 1. Posterior View

vaccinated for smallpox in the right deltoid area, 19 years previously. The patient had been exposed to smallpox while driving a school bus. At the time of the smallpox vaccination, the county health officer also gave a parenteral injection along the anterior border of the right deltoid muscle. Probably this was diphtheria toxoid. Immediately following the immunizing procedures, the patient developed such a severe reaction in his right upper extremity that he had to carry the swollen painful limb in a sling for eight days. The tumor never became smaller. One year later it was about two inches long. Ten years later it was about three inches long. Growth had been more rapid in the last year. Aspiration of the tumor by the family doctor in October 1949 resulted in a dry tap.

The tumor hung vertically and was somewhat club shaped. It was 16 centimeters long and 8 centimeters in diameter in its distal third, where it was largest. Except for the proximal 4 centimeters the skin which covered the lesion was anesthetic. On December 24, 1949, the tumor was removed under local anesthesia. It weighed 320 grams. The wound healed per primam. Pathologic sections were taken through several levels of the tumor and at its base. Histologically it proved to be a benign lobulated lipoma. In the accompanying picture the tumor was lifted outwardly for better exposure of its pedicle.—Carl A. Minning, M. D., Williamsburg, Ohio, March 13, 1950.

The Immediate Supportive Treatment of the Severely Burned Patient

JAMES MITHOEFER, M.D.

WHEN one is presented with the problem of the severely burned patient the local treatment of the injury no longer causes much concern or is subject to major decisions as to what type of treatment should be used. Since Koch, Mason and Allen[1, 2] developed their rational plan for the treatment of burns by cleansing and the application of a bland ointment pressure dressing under aseptic conditions, this method has been used in many centers and by the armed services during World War II with considerable success. This method of treatment has become so standardized that it is familiar to almost everyone. We are still presented, however, with the serious problem of correction of the general physiologic abnormalites that occur in the body of the severely burned person.

Uncertainty is apt to exist in the first 48 hours following burn as to how the disturbed electrolyte pattern of the patient's blood can be corrected, how his so-called shock should be treated, and how his urine output may be maintained. This paper is presented not as an original contribution to the solution of these problems, but as a critical review of the existing methods of treatment and as a tentative plan which has been of some use to us in handling persons with third degree burns. It should be pointed out at the start that the various abnormalities to be discussed do not often arise in patients with second degree burns unless they are extensive, but a deep third degree burn, because of its destruction of tissue, may produce serious physiologic abnormalities even though the area of the burn is relatively small.

It is the plan of this review to take up separately the major manifestations caused by a severe burn and discuss each one in some detail. Using the information thus available, we shall present in as simple fashion as possible an outline which may be applied, with some modification, to any individual patient.

RESTLESSNESS

The first treatment that a severely burned patient usually receives is the administration of some narcotic to control his severe hyperactivity. Morphine is usually administered for the relief of pain. One must remember that its purpose is the control of pain and that its analgesic effect increases with the amount of drug up to a dose of about 10 mg. If more than 15 mg. is given the analgesic effect becomes less pronounced with each increment of dosage and the undesirable side effects such as depressed respiration and vomiting become more apparent. If pain is not relieved by the administration of 15 mg. of morphine to a burned patient one may properly assume that any remaining restlessness is not due to pain. It is often due to apprehension and to fear which is induced by the obvious severity of the injury. Morphine has very little effect upon the higher cerebral centers in controlling this type of restlessness. However, a dose of 0.1 to 0.2 Gm. of phenobarbital or another of the barbiturates is usually effective.

Another common cause of restlessness and one which must be recognized and treated adequately is that secondary to cerebral anoxia. This may be caused by decreased circulating blood volume and failure to deliver a sufficient supply of oxyhemoglobin to the brain, or it may be due to impaired respiratory exchange. The treatment of the former will be considered in some detail below. Reduced respiratory exchange is commonly due to two causes. First, there may be edema of the walls of the respiratory tract caused by the inhalation of hot gases. Secondly, there may be respiratory depression following an overdose of morphine. In either event, the treatment resolves itself into the delivery of adequate amounts of oxygen to the lungs. The administration of oxygen by mask or by nasal catheter should be a constant treatment in all severely burned patients. Occasionally one sees a person with enough laryngeal edema to require tracheotomy. If this procedure is indicated it should be done promptly. It is far better to make an unnecessary tracheotomy than to deny the patient a free airway if one is needed. When clinical signs of pulmonary edema are present relief may be afforded by the administration of oxygen under positive pressure.

DECREASED BLOOD VOLUME

Perhaps the most important single early manifestation of a severe burn is that due to decreased

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circulating blood volume, a condition commonly known as shock. Blood volume is diminished both relatively and absolutely. Careful measurements of the extracellular space have shown that in a severe burn of more than 25 per cent of the body surface there is an increase of 50 per cent in the extracellular compartment in the first 48 hours.[3] Associated with this is less blood to fill up the intravascular space. Blood is lost to the circulation in several ways. There is damage to the capillaries with the escape of whole blood. The red blood cells are hemolyzed by heat and perhaps by exposure to potassium released by other destroyed cells and to the osmotically altered serum;[4] they are trapped in the burned tissue and the adjacent vessels.[5, 6, 7] The redness of the skin of areas of second degree burns indicates vasodilatation with stagnation of blood and loss to the circulation. The cell free fraction of the blood is poured out of the capillaries into the vesicles and into the interstitial spaces and manifests itself by the presence of edema.

The correction of the diminished blood volume is one of considerable emergency as shock may become irreversible if it is allowed to exist long enough, as irreparable damage to the liver and brain and the kidneys may result. When the patient is seen soon after the burn is incurred signs of shock may not be manifest. However, the astute clinician will anticipate impending shock and institute appropriate treatment before the signs are present. It is generally agreed that the prevention of shock is more satisfactory than its treatment. Therefore, at the first opportunity some type of fluid must be given intravenously in an effort to increase the arterial pressure and deliver an adequate supply of blood to the vital organs. If nothing else is at hand in the emergency physiologic saline solution may be used until plasma or whole blood is available. The fluid of choice is whole blood.

It must be pointed out that the diminished blood volume is due to loss of more than pure plasma. Studies of the changes in red cell mass following burns have indicated that from 5 to 55 per cent of the lost blood volume is composed of red blood cells.[6] The average volume per cent of red cells in the lost fluid is 31 per cent, which is the equivalent of slightly anemic blood. It has been demonstrated in experimental animals that there is a greater incidence of recovery following severe burns when whole blood is given.[8] These findings have been confirmed in human subjects.[9] No investigator has reported any danger associated with the administration of whole blood even in the presence of marked hemoconcentration with a hematocrit level as high as 85 per cent.[6] The administration of whole blood at this time instead of plasma largely prevents the secondary anemia which seems to appear several days after a burn but which has really been present since the beginning but has been masked by hemoconcentration. Furthermore, in the reported studies and from our personal observations it appears that patients are less inclined to vomit, take more food and fluid by mouth, feel better generally, and have a more benign subsequent course if whole blood is supplied to them early in adequate amounts. From the available data it seems that blood must be furnished to a severely burned patient in amounts equivalent to about 10 per cent of the body weight in the first 48 hours.[3] It has become our practice to attempt to supply this amount of blood. If the hematocrit rises above 80 per cent we have generally switched to the administration of plasma in similar amount, changing over to blood again if the hematocrit falls below 80 per cent.

TRANSLOCATION OF WATER AND ELECTROLYTES

One of the most difficult problems encountered in the early treatment of the severely burned patient is the administration of the proper amounts of water and of the various electrolytes by the proper routes. It is apparent to anyone who observes the marked edema in and about a burn that there is serious translocation of body water and its solutes which are lost to the internal environment when they are extravasated into the interstitial spaces.

For the purpose of this discussion let us first consider the volume of water which should be given. If one observes an untreated burned patient he observes that little or no urine is excreted. Anuria and oliguria may be due to one or a combination of three factors:

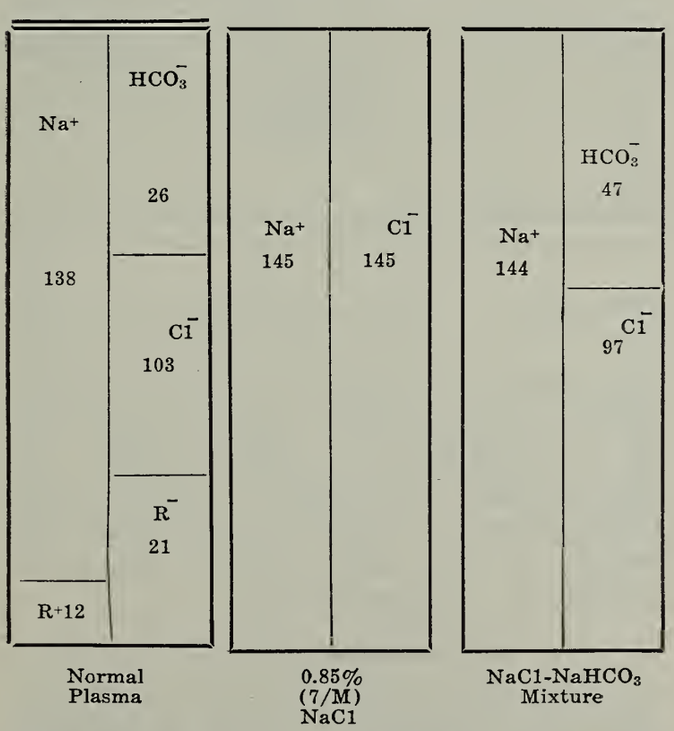
1. Insufficient circulating blood volume for glomerular filtration.
2. Renal tubular damage.
3. Insufficient intake of water.

The first factor will be controlled by the adequate treatment of shock. If one is able to maintain a normal arterial pressure in the arm, the presumption is that the pressure in the renal circulation is also adequate. In that event, the other two causes may be differentiated by testing the renal tubular function by the rapid administration of water. If 500 to 1000 cc. 5 per cent glucose in water is given intravenously at a rapid rate—that is, in from 30 to 60 minutes, there will be immediate reflection in increased urine output if the tubules are functioning and one may assume that the oliguria was due to dehydration. Once renal competency is established the urine output is the best single guide to the continued administration of fluid. If urine output is kept at about 50 cc. per hour one may be sure that adequate water is available for metabolism.

The route by which the aqueous solutions are to be given is of great importance. It has been demonstrated that experimentally burned

animals survive in greater numbers and for longer periods of time if they are given only blood parenterally and water and salts by mouth;[8] these findings have been confirmed by observations on burned patients.[9, 10] We have, therefore, adopted the policy of giving nothing but blood or plasma intravenously and giving all water and electrolytes by mouth. If the patient vomits or has paralytic ileus, which is not infrequently the case in children, one must give the aqueous fluids subcutaneously. Rarely it will be found necessary to use the intravenous or bone marrow route.

Aside from the loss of extracellular fluid into the tissue spaces, there is considerable translocation due to loss of electrolytes. In the immediate period after a deep burn there is an excess of serum potassium from the destroyed cells. This ion must be excreted by the kidneys, taking with it bicarbonate ion; thus the bicarbonate-carbonic acid ratio is disturbed, lowering the pH so that acidosis results. Later there is loss of chloride into the burned areas and also in the urine. In an attempt to correct these disturbances we have recently been administering a mixture of roughly 7/M Sodium chloride + 7/M Sodium bicarbonate in the ratio of two parts of the former to one part of the latter. The reason for using this mixture can be appreciated by studying the diagrams below:



The figures represent milliequivalents per liter of solution.

It is apparent that so-called normal saline bears no quantitative relationship to normal plasma except in osmolarity and that it supplies a great deal too much chloride in relation to the concentration of sodium ions.

The saline-bicarbonate mixture is more nearly physiological in that respect and in addition it contains nearly twice the normal plasma concentration of bicarbonate which will help to correct the acidosis.

If it is necessary to give water and electrolytes parenterally we have substituted 6/M Sodium lactate for the bicarbonate and have given the solution intravenously or we have used 7/M Sodium chloride solution subcutaneously.

It must be emphasized that when this solution is given, one must determine the serum pH and CO_2 content every 3-4 hours because within the first 12-15 hours after the burn there may be a rather sudden shift to alkalosis in which case the electrolyte content must be adjusted accordingly.

PLAN OF TREATMENT

Treatment without a definite plan and without an understanding of the reasons for using each therapeutic tool is at best uncertain and often disastrous. In our experience the following brief outline and check list has been helpful in the early management of serious burns.

ESTIMATE EXTENT OF BURN

Any burn of more than 10 per cent of the body surface is potentially serious and the patient should be admitted to the hospital. An accurate diagram of the extent of the injury should be made and the percentage of second degree and third degree burn estimated.

GENERAL PHYSICAL EXAMINATION

A thorough but quick general examination should be made. Special attention should be paid the following points:

1. Eyes: Are there burns of the lids or corneas?

2. Nose, mouth, pharynx: Are there signs of burns which might indicate the inhalation of hot gas?

3. Lungs: Are there signs of pulmonary edema which might be caused by inhalation of noxious fumes or hot gas?

4. Are there signs of associated trauma such as fractures, lacerations, intra-abdominal, intrathoracic or intra-cranial injury?

5. Heart: The cardio-vascular system in general must be carefully evaluated because shock is either present or impending and as the situation becomes more complicated a knowledge of the patient's normal condition becomes more valuable.

6. Estimate the patient's weight. This will be of utmost value later in estimating the fluid requirements.

ASEPTIC PRECAUTION

From the time the patient is first seen it is imperative that the strictest aseptic conditions be enforced. All personnel must be masked. The patient must be placed on and

CHECK LIST FOR SEVERE BURNS

Hour 0

Phys. Exam.
Eyes
Nose
Mouth
Pharynx
Lungs
Pulse
B. P.
%3°
%2°
% Total
Temp.

Morphine
Dose

Barbiturate
Type
Dose

Oxygen
Cath.
Mask

Other

Hematocrit
Hemoglobin
Rbc
Wbc
Serum
Cl^-
CO_2
pH
BUN
Creatinine

Body Weight
kg.
Catheter
Dressing
Time
Anaesthetic

½

Pulse
Respirations
Mental Status
Oxygen
Stridor
Rales

1

Pulse
Resp.
Temp.
Mental Status
BP
Urine output
Stridor
Rales
Am't. blood or plasma
Gm NaCl
Gm $NaHCO_3$
Amt. Water enteral parenteral

2

Pulse Temp. Resp. BP Metal Status Urine
Stridor Rales

3

Phys. Exam.
Eyes
Nose
Mouth
Pharynx
Lungs
Pulse
Mental Status
BP

Urine
Volume
Sp. gr.
H'crit (or Hb)

Serum
pH
Cl^-
CO_2

Morphine
Barbiturate
Am't. blood or plasma
Am't. water enteral parenteral
GmNaCl
Gm $NaHCO_3$

4

Pulse Temp. Resp. BP Urine vol.

5

Pulse Temp. Resp. BP Urine vol.

6

Phys. Exam.
Eyes
Nose
Mouth
Pharynx
Lungs
Pulse
Temp.
Resp.
BP

Urine
Vol.
Sp. gr.
H'crit (or Hb)

Serum
Ph
CO_2
Cl^-

Amt. blood plasma
Amt. water enteral parenteral
GmNaCl
Gm $NaHCO_3$
Morphine
Barbiturate

Thereafter at least *every hour* check (1) Urine output (2 Circulation (3) Respiratory distress. Adjust water intake and blood or plasma infusion accordingly.
Every three hours check hemoglobin or hematocrit.
Every six hours check (1) Serum electrolytes (2) Urine specific gravity (3) Amount of electrolytes given (4) Do general physical examination.

covered by sterile sheets until the occlusive dressings may be applied.

BLOOD STUDIES

These are divided into two parts:

A. The determination of the cellular elements:
1. Hematocrit
2. Hemoglobin
3. Erythrocyte count
4. White blood cell count

These determinations are chiefly of value in estimating the degree of hemoconcentration.

B. The determination of the soluble constituents:
1. Chlorides
2. Bicarbonate content
3. pH.
4. Blood urea nitrogen or nonprotein nitrogen
5. Blood creatinine

The first three mentioned determinations will serve as a base line to determine the immediate fluid therapy. The last two will serve as a measure of renal function. The creatinine will be of value later in deciding whether an elevated blood urea nitrogen or nonprotein nitrogen is due to impaired renal function or to bleeding into the gastro-intestinal tract from gastritis or a Curling's ulcer.

OXYGENATION OF BLOOD

Oxygen should almost invariably be given, by mask, by catheter, or by tent. If laryngeal stridor is present, tracheotomy must be performed forthwith. If pulmonary edema occurs the prognosis is poor, but improvement may occur if oxygen can be given under positive pressure.

SEDATION

Morphine 10-15 mg. is given for the relief of

$$\frac{\text{Chloride expressed as mg NaCl per 100 cc. x 10}}{58.5} = \text{mEq } Cl^-/L$$

$$CO_2 \text{ combining power expressed as vol. \% x 0.423} = \text{mEq } HCO_3^-/L$$

$$\frac{\text{NPN expressed as mg per 100 cc. x 10}}{28} = \text{mEq NPN/L}$$

pain, and one of the quick-acting barbiturates 0.1-0.2 Gm. to promote mental ease.

MAINTENANCE OF CIRCULATING BLOOD VOLUME

A large vein must be cannulated early and the administration of whole blood is to be started as soon as possible. While awaiting cross-matching of the blood, preserved plasma should be given. One may estimate that about 10 per cent of the body weight of blood or plasma will be required in the first 48 hours. The rate of infusion cannot be told accurately. It should be given at such a rate that the blood pressure and pulse are brought to normal values and kept there. If the hematocrit rises above 80 per cent or if there are more than 30 grams of hemoglobin per 100 cubic centimeters of blood one is justified in changing the infusion to plasma or a mixture of plasma and blood. The value of intra-arterial transfusion in cases of extreme hypotension must not be forgotten.

MAINTENANCE OF URINE OUTPUT

Almost all severely burned patients should have an indwelling urethral catheter placed soon after admission. An accurate record of the urine flow per hour can then be kept. Water and its solutes are given by mouth, by stomach tube or, if necessary, parenterally at such a rate that the urine flow is kept as close to 50 cc. per hour as possible. Usually 1000-3000 cc. of water will be required to replace the loss from the burned area in the first 24 hours and about 2000 cc. to compensate for the insensible loss. Adequate renal function cannot be maintained unless the arterial pressure is kept high enough to insure glomerular filtration. Renal tubular damage may also be a factor if there has been prolonged hypotension or severe hemoglobinuria. Tubular function may be tested by the rapid administration of water as described above.

MAINTENANCE OF ELECTROLYTE BALANCE

The water intake described above will at the outset of treatment contain the 1:3 bicarbonate-saline solution previously mentioned except if it is given subcutaneously. Each liter of this solution will contain 5.6 Gm. NaCl and 4.0 Gm. $NaHCO_3$, or, expressed physiologically, 144 mEq Na^+, 97 mEq Cl^-, and 47 mEq HCO_3^-. If at any time during the course of treatment the bicarbonate content of the serum (as calculated from the CO_2 combining power) rises above 30 mEq per liter or if the pH rises above 7.7, the bicarbonate content of the mixture will be reduced proportionately.

Unfortunately the amount of chloride ion which should be given cannot be so readily determined. The serum chlorides are notoriously unreliable as a guide to therapy. It is dangerous to rely on the excretion of chloride ion in the urine as a guide to therapy because in the first few days following a severe burn there may not be any significant excretion even when large amounts are given. Empirically it seems that the equivalent of 12-17 Gm. NaCl suffices to supply the chloride requirements for 24 hours.

It will be noted that the values for the various chemical determinations are all given in milliequivalents per liter to promote better understanding of the electrolyte pattern. Since many hospital laboratories report their results in other ways, the factors, set apart at the top of this page, are given for their ready conversion to the physiological units.

If these principles are kept in mind the check list on opposite page will serve to stimulate the memory about the many details necessary in the treatment of a severe burn. It will also serve as a running inventory, so to speak, of the patient's status at any particular time. It will be noticed that the check list sheet covers a six-hour period. Each additional six-hour period may be recorded on a separate sheet. At the end of 24 or 48 hours the period of urgent replacement therapy is usually at an end as demonstrated by stabilization of the patient's condition.

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Intestinal Obstruction Caused by Spasm of Colon—A Case Report

WILLIAM D. MONGER, M. D.

IT is theoretically possible for intestinal spasm to occur long enough to cause obstruction because of the known ability of smooth muscle for prolonged contraction without fatigue, and cases have been seen and reported by Wangensteen, causes being given as:

1. Irritation, either from without or within the bowel, such as foreign body, worms, ulcers, or external trauma;
2. Poisons, lead or arsenic;
3. Psychic, neurasthenia and hysteria;
4. Idiopathic.

It would seem likely that some cases in the idiopathic category might be due to visceral angioneurotic edema, though if intestinal obstruction occurs on an angioneurotic or allergic basis it is usually due to edema of the bowel wall occluding the lumen. A case of an acute abdominal emergency in an allergic patient may deserve a therapeutic trial of epinephrin before final decision for laparotomy is made.

CASE REPORT

History: A sixty-two-year old glassworker not in contact with lead was first seen in March 1949 complaining of abdominal cramps of twenty-four hours duration, with nausea and vomiting for a few hours. He had had a previous inguinal herniorrhaphy, two rectal operations for abscesses, a suprapubic prostatectomy, and a coronary occlusion, the last about one year ago.

Physical findings, positive: He was severely ill, with vomiting simultaneous with severe abdominal cramps. Blood vessels markedly sclerotic. The abdomen was moderately tender, more so in the lower half with moderate distension and the bowel pattern was visible. No increased peristalsis and no rushes were heard. Rectal revealed only a tight band posteriorly at the anus.

Temperature, pulse, respiration, and blood pressure normal.

He was of a nervous, apprehensive type.

Laboratory findings. Erythrocytes 4.92 millions, 96 per cent hemoglobin. Leucocytes 19,000 with 3 per cent lymphocytes and 97 per cent neutrophils with 4 juveniles, 40 bands and 53 segmenters.

Voided urine had 45 milligrams albumin with 2 Red Blood Cells/High Power Field and 4 plus casts. Specific gravity quantity not sufficient.

Flat plate of the abdomen showed considerable distension of the small bowel.

Course: He was given gastric suction and intravenous fluids. Laparotomy, performed the next day, showed a tight spasm in the middle of the transverse colon with dilatation of all bowel proximally and collapse distally. The colon at the site of spasm was otherwise normal, and was caused to dilate by compression proximally and remain so under observation. Mesenteric lymph node biopsy showed chronic lymphadenitis and culture of a slight collection of free peritoneal fluid was negative.

Postoperatively he did very well and no obstruction occurred until six weeks later, at which time distension, cramps, and nausea and vomiting recurred. He was readmitted to the hospital and given gastric suction for two days with nothing by mouth and intravenous fluids. He has been well for a period of seven months.

A similar case was seen on the wards at Ohio State University in 1939.

Submitted Feb. 3, 1950.

The Author

● Doctor Monger, Lancaster, Ohio, is a graduate of Ohio State University College of Medicine, 1942, and received his surgical training at Nashville General Hospital in Tennessee. Now engaged in practice at Lancaster.

SUMMARY

1. Causes of intestinal obstruction due to spasm of the bowel are listed.

2. A case of spasm of the colon causing obstruction is detailed and another one mentioned.

Studies of Toxoplasma in Tissue Cultures

Toxoplasma were maintained in hanging drop slide cultures of mouse tissues (i. e., spleen, liver, heart and brain) in the plasma clot and under perforated cellophane.

After 33 days in tissue cultures, these organisms no longer caused an acute infection in mice; however, a chronic type of infection occurred. A detailed morphological study of the organism was made using the light, phase, and electron microscopes, and the effects of Toxoplasma on various tissues grown in cultures were studied.

The practicability of tissue culture antigens for use in skin testing is discussed.

—THEODORE SUIE, JR., M. D.,
JACKSON W. RIDDLE, Ph. D., M. D., and
AUTHUR M. CULLER, M. D.,
Columbus, Ohio.

Brief authors' abstract of paper presented at charter session of the Association for Research in Ophthalmology, East-Central Section, held in Cleveland, Jan. 10, 1950.

Inguinal Herniation of Stomach: Case Report

TOM F. LEWIS, M.D., and PAUL S. ROSS, M.D.

OCCASIONALLY, cases are encountered that are of interest because of the presence of some unusual features. In this case, these unusual features were the great size of the hernias, and the fact that one of them actually contained both stomach and small bowel. Repair was carried out successfully. Case report follows:

Mr. T. W. G., age 69, was first seen as an outpatient in December, 1947, complaining of two large hernias that could be retained only five to six hours at a time by a truss. He stated that both had been present since the age of 20, and that for the past 15 years he had tried numerous appliances to restrain them without success, chiefly because of intolerance to the degree of pressure necessary. The hernias had reached their maximum size about 20 years ago, and had caused gradually increasing discomfort, but had given him no great difficulty otherwise, except that he was unable to eat with any particular degree of comfort.

X-ray studies at this time (See Fig. 1) showed the presence of the stomach in the right hernial sac, and many loops of small bowel in the left sac.

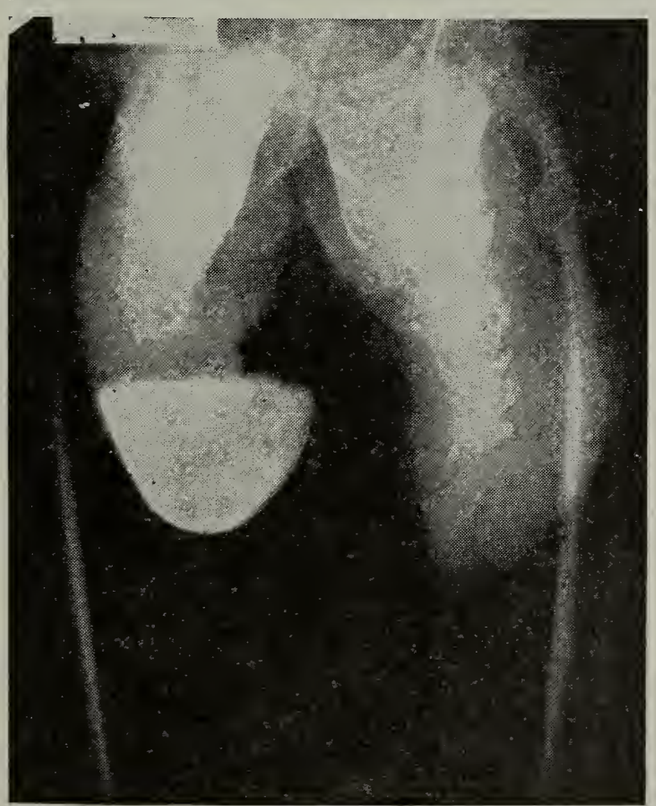


FIGURE 1

Examination revealed a frail, elderly man, age 69, weight 92 pounds, who presented huge bilateral inguinal hernias, each about the size of a football, and both easily reducible. This patient was advised to consider surgery.

Submitted April 7, 1950.

The Authors

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● Dr. Ross, Columbus, Ohio, is a graduate of Yale University School of Medicine, New Haven, Conn., 1931; diplomate, Nat'l. Board Medical Examiners; diplomate: Amer. Board of Internal Medicine; Amer. College of Physicians (Assoc.); Amer. Heart Association; chief of Medicine, St. Anthony's Hospital; and on attending staffs at White Cross and Mt. Carmel Hospitals; asst. clin. prof. of Medicine, Ohio State University.

When next seen in May, 1948, he had had several bouts of vomiting and a further slight weight loss. Physical examination at this time was negative, except for the hernias and extreme emaciation. He was again advised to have surgery, and finally in October of 1948, was hospitalized to have it carried out.

Physical examination at this time showed an extremely thin individual, of about the stated age, weight 95 pounds. Blood pressure 130/70. Eye, ear, nose, and throat examination and examination of the heart and lungs were negative. The inguinal regions revealed bilateral inguinal direct hernias of huge proportions, each about the size of a football. Both were easily reducible, both defects easily admitting three fingers. Rectal examination revealed no palpable prostatic enlargement. Admission urinalysis was normal except for a few bacteria and a trace of sugar. The Blood Urea Nitrogen was 14, total protein 5.58, albumin 3.39, globulin 2.19, prothrombin content 100 per cent. The blood count revealed red blood count 5,000,000, white blood count 10,200, hemoglobin 14.5 gms., and a normal differential. The blood sugar showed a non fasting level of 135 milligrams per cent and a fasting of 82. Examination of the extremities revealed them to be rather cold to touch, and there was no pulsation palpable in the dorsalis pedis, posterior tibial, or popliteal vessel in either lower extremity. His vital capacity measured while at bed rest with the hernias reduced was 3100 cubic centimeters; and while ambulatory with the hernias in the scrotum, it was 3000 cubic centimeters. This test was carried out to ascertain whether or not the return of the hernial masses to the abdominal cavity would seriously embarrass the vital capacity.

X-ray Reports. G. I. Tract: Fluoroscopic and film studies of the esophagus, stomach, and

duodenum showed barium to pass through the esophagus without difficulty. The barium then progresses through a markedly elongated ptotic stomach and the angle, pylorus and duodenal bulb are situated in a huge scrotal sac on the right. This is well demonstrated on the films made in the erect and recumbent positions. It appears that multiple other loops of intestine are also present in this tremendous hernia. Chest: The cardiac shadow is small in size and normal in position. The domes of the diaphragm are flattened and low in position. There is a Ghon tubercle in the middle third of the left lung and slight calcification in the hilum. There is no evidence of active tuberculosis or malignancy. The chest appears emphysematous.

Operation on one side was undertaken on October 16, 1948. The right inguinal canal was opened, the contents of the scrotum having been replaced previously without difficulty. A large defect both direct and indirect, but mostly medial to the deep epigastric vessels, was present. The elongated deep epigastric vessels were divided, the huge sac dissected free, amputated at its neck and closed with interrupted mattress sutures of silk. A modified McVey type of repair was carried out, splitting Cooper's ligament longitudinally, suturing the medial flap to the posterior rectus sheath, the lateral flap to the anterior sheath, and using relaxing incisions in this layer. The cord and testicle were removed to assure a more complete and secure closure, and the external oblique fascia was closed. Silk was used throughout. Over this, a piece of Tantalum gauze was applied to further reënforce the repair.

Following this operation the patient had rather persistent residual urine, which was treated by insertion of a Foley catheter and early ambulation was begun. The patient was extremely difficult to feed, having very little appetite, and his diet was supplemented by vitamins and iron. He was given sulamyd® 1 gm. three times a day and duracillin® 1 cc. twice a day to control and prevent any bladder infection. His postoperative course was otherwise uncomplicated.

The second operation was carried out on November 2, 1948, for the left direct inguinal hernia, after fully reëvaluating his physical status. The sac was approached through an oblique incision in the inguinal region, the inguinal canal opened and the sac dissected free. It was found to consist of a large direct sac and a smaller indirect one. These two were combined into one, changing it from a pantaloon type to a simple type of sac. This was resected and the neck closed with silk mattress sutures. The hernial repair was then carried out using the posterior sheath of the rectus muscle with the transversus abdominis aponeurosis approximated to Cooper's ligament. No relaxing incision was needed. The deep inguinal ring was made smaller and the cord was dropped beneath the external oblique fascia, and satisfactory repair was completed by closing this layer over the cord, creating a new subcutaneous ring.

Follow-up examination on December 6, 1948, showed an excellent postoperative condition. X-ray examination at this time (See Fig. 2) discloses the stomach and intestines to be entirely intra-abdominal and in near normal position. The Tantalum gauze can be clearly seen *in situ* covering the previous location of the right direct inguinal hernia.

The scrotum was enlarged, the left testicle slightly tender. One knot of Tantalum over the midline was rather prominent. On December 29, 1948, a few infected sutures at the lower angle of the left wound were removed, and he was seen again on January 3, 1949,



FIGURE II

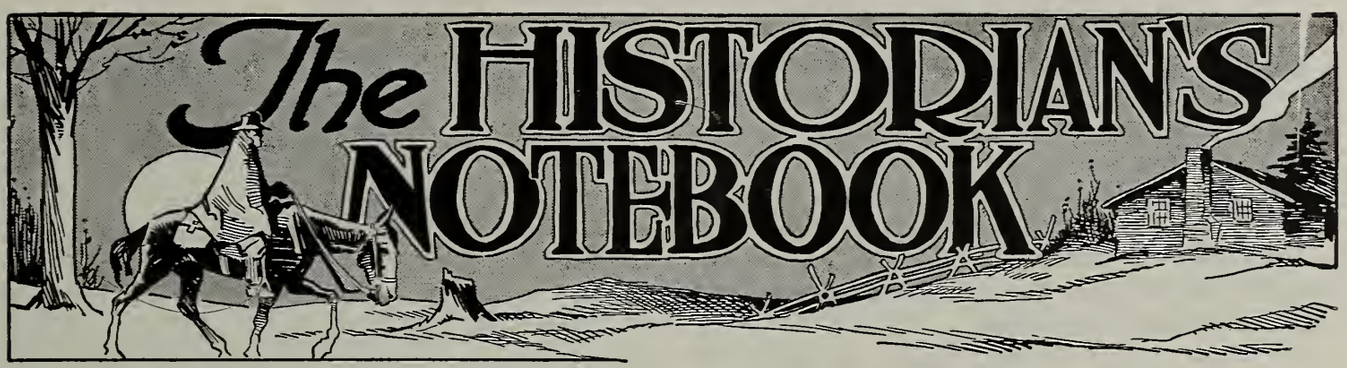
at which time his condition was excellent and he was gaining weight steadily.

At the present time, February, 1950, his condition is good, and the repairs are holding well.

COMMENT

It is also felt that this case is unusual for a number of other reasons. First, direct inguinal hernia rarely occurs before the age of forty. These hernias existed since the age of twenty. Secondly, the right direct inguinal hernia contained part of the stomach, part of the duodenum and loops of upper jejunum. Herniation of the stomach, while occurring in diaphragmatic and umbilical hernia, has rarely been reported as occurring in an inguinal hernia. In addition, a large portion of the ileum was present in a similar hernia on the left side, so that it truly may be said that much of the patient's main digestive tract was situated extra-abdominally.

In spite of this extreme abdominal visceral dislocation, this patient had existed several decades with only periodic digestive upsets. He was able to reduce, but not restrain his hernias and suffered severe nutritional upsets only in the last year of his illness. Since successful surgical correction of this condition, the patient has been completely asymptomatic and his nutritional status has improved.



Development of Dermatology in Ohio

Part I

LEON GOLDMAN, M. D.

IT is a gratifying feeling to return to the study of the history of medicine even though it be in a superficial and casual survey, such as I must make this. Paul Bechet thinks it always good for one's ego in medicine to read back into history. Please do not be misled by this pompous title, because this report will be merely a summary of trends rather than a specific or cyclopedic array or even information by gossip. The history of trends here will illustrate both the developments of dermatology in Ohio as it influenced American dermatology and also the picture in Ohio as part of the background of the national scene. I shall omit much, especially names of many who have been present in these scenes, for this is not a detailed review. I have been helped, in this report, by my colleagues because fortunately, some dermatologists in Ohio have also been medical historians, for example, your own Clyde Cummer, and also in Cleveland, William Thomas Corlett and Willard L. Marmelzat and in Cincinnati, Charles Tabb Pearce and Roy Kile.

Even from Corlett we have very little information available as to the interest of the Indian medicine man in the "Ohio territory" in dermatology. I wonder whether such peculiar interest to diseases of the skin was exhibited anywhere in the Americas, except perhaps in Peru. The teaching of Medicine, as our Father of Western Medicine, Daniel Drake, showed, included the teaching of dermatology as part of the general medicine. His section on the Eruptive Fevers, Part IV of Book II of A **Systemic Treatise on the Principal Diseases of the Interior Valley of North America** shows the current information on this subject, as influenced chiefly by Willan and others of that period. Willan and Bateman on cutaneous diseases and Bell and Hunter on venereal diseases had been recommended as textbooks at the first medical convention of Ohio in Columbus on June 4, 1821.

The Author

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EARLY TEACHINGS PERTINENT TODAY

Some of the ideas of this great teacher and practitioner, Daniel Drake, are indeed pertinent for today. He wrote of a group that still distresses and confuses us; he called this group, "Roseola, lichen and strophulus." "As they are all more or less papulous, as in their acute forms, the efflorescence is preceded by feverishness, and tends in most of them to produce a branny desquammation, it is easy to perceive that the labor of studying their diagnostic relations is not small. Moreover, most of them occur but seldom; very few of them require medical aid, and all or nearly the whole are free from danger. Opportunities and motives then for studying them do not in fact exist, and the most deligent inquiry among our physicians

From the Department of Dermatology and Syphilology of the College of Medicine of the University of Cincinnati and the Cincinnati General Hospital. Presented at Ohio State Archeological and Historical Society Annual Meeting, Columbus, April 14, 1950.

could not bring out much that would be worthy of publication." The technic of the presentation of the detailed individual case report is a worthwhile clinical teaching aid and his ideas in that section revealed that he was certainly far advanced even in this field of dermatology. If dermatology was among the things Daniel Drake was supposed to undertake-too-much of, his so-called discursiveness here is still appreciated by dermatologists of today.

For some years I have been interested in the old case books of our old hospital and have followed the notes of the physicians of the bygone days as they have made their ward visits and examined the river men from the Ohio river and the other motley crews. One of these books from the Cincinnati Hospital and Lunatic Asylum, was the case book of J. T. Shotwell and J. P. Judkins of 1837. I have mentioned before the note of John T. Shotwell —March 10, 1837. "There is not a single record in the medical department nor a single instrument in good repair. Most of the cases of instruments have lost one or more important pieces." Those of you who have the honor to work in general hospitals will have residents who today re-echo the piteous wail of this Resident Physician in 1837. There were a large number of leg ulcers which could have been anything. Even today, the leg ulcer problem is still the serious economic problem for my patients and my Service. One group in the Surgical Ward Case Book, **Clinicum Chirurgicum of 1837**, was described as "ulcers occasioned by intemperance" and in another patient, whose ulcers were suspected by being syphilitic, "In relation to his infirmities, we might well exclaim in the language of the philanthropist 'Alas poor human Nature!'" What dull all too brief notes we inscribe today! We read also where the renowned Blackman did something that surgeons of today would never have the nerve to do, we hope;—attempt to describe a combination of palmar psoriasis and lichen! Unlike this modern world, the acute venereal diseases, or what was called that, outnumbered the non-venereal skin diseases.

NOBLE PIONEER IN AMERICAN DERMATOLOGY

It is always customary for us in dermatology in Ohio to point with pride to our Noah Worcester. He, in spite of his active tuberculosis, was first, Professor of Physical Diagnosis and Pathology at the Medical College of Ohio in Cincinnati, 1842-1843, and then Professor of General Pathology, Physical Diagnosis and Diseases of the Skin at Western Reserve, and with it all, practiced dermatology both in Cleveland and Cincinnati and commuted between Cincinnati and Cleveland. Delamater with his famed monograph, Cummer and Marmelzat have studied this noble pioneer in American dermatology.

This is not the place to review his work in terms of interest to the development of dermatology, but only to mention that his book was one of the significant beginnings of American dermatology, since it was the first American textbook on dermatology. To show his deep appreciation of the problem then (and even now) of teaching clinical dermatology, I should like to quote from the preface of his book of 1845.

"A concise and accurate treatise, in our language, upon Cutaneous Diseases, illustrated by well executed plates, that can be afforded at such a price as to be within the reach of all, has been needed for a long time. The design of this Synopsis, was to supply this want; and if the Author has succeeded in giving a correct description of the more common forms of these affections, illustrated by well executed plates, with the most appropriate treatment, his object has been attained.

"Utility and not originality has been his design; he has drawn information from every source within his reach, and it is hoped that he has proved in this compendium that he has studied with some care, the works of Willan, Bateman, Alibert, Cazenave, and Schedel, Plumbe, Thompson, Rayer, Wilson, Gilbert, Erichsen, Ricord, Baumes, etc. The figures have been selected from Willan & Bateman, Thompson, Rayer, Alibert, Wilson, Erichsen, Cazenave, and Ricord; and it is believed they will be found well executed. No one has taught this much neglected branch of Medicine, that has not felt the want of such a treatise as this is intended to be; and it is the hope of the Author that it may be found to supply this deficiency.

"At first it was my intention to treat of the Eruptive Fevers in this Synopsis; I was deterred from doing so by the consideration, that the eruption in these affections is only a symptom of the treatises on Theory and Practice of Medicine, and that the principles of diagnosis were comparatively well understood."

As Marmelzat has pointed out, it was thirty years before another textbook on dermatology was published in the United States. With the renewed interest in Noah Worcester, we trust that he will not continue to be known as the "Forgotten Pioneer."

Ohio then shared in the almost universal neglect of dermatology as a specific teaching subject and as specific practice for some years. Gradually, the large centers began to become aware of the rise and development of dermatology. It was in this period that specialism was practically non-existent, or where it attempted to develop, it was promptly put down. As medicine progressed, however, tolerance developed even towards the so-called minor specialties. This was the period which Bechet described when the leaders in American der-

matology "lived, and worked at a time when diagnosis and therapy depended almost entirely on a keenly observant mind, careful and exhaustive physical examinations, clinical notes and the observation of thousands of dermatologic cases, therapy developing a clinical acumen unusual in this day of almost complete dependence on the laboratory, and diagnostic machines."

Great changes were occurring in the Ohio scene as regards urban development, concentration of people in cities, development of large hospital centers and the consequent public and private health problems resulting from these changes. There was apprentice and student teaching and the ever-present-squabbles of the medical groups. These changes in Ohio medicine have been reported in detail by the medical historians of Ohio.

EARLY NATIONAL FIGURES

Following these rough beginnings of specialism, a few national figures began to appear in Ohio. Augustus Ravogli of Cincinnati spent two years in postgraduate training in Prague, Vienna, Paris and Berlin. In 1889 he became Professor of Dermatology in the Ohio Medical College and in 1894 Professor of Dermatology at the University of Cincinnati. Before Ravogli, Pearce mentions a Dr. Longfellow who soon left for Toledo. In Cincinnati, at that time and foreshadowing some activities of present day dermatology, we note that in one hospital group B. M. Ricketts and A. V. Phelps had been assigned to a special service of plastic surgery and skin. A. G. Drury was professor of dermatology at the Laura Memorial Medical School in Cincinnati. Shortly afterwards was the rise of the Cleveland School as detailed by Clyde Cummer and Marmelzat. Marmelzat has detailed the long struggles of Corlett against the indifferences of the physicians of that time. His period dates from 1882, his lectureship on skin and genito-urinary diseases in the Medical Department of Wooster University, and his free skin clinic, to his professorship at Western Reserve. This position he held until 1914. Cummer mentions the early days of the period of 1910 to 1915 when the medical students had scanty opportunity to see any variety of clinical dermatologic material. Then Harold Cole came into the Department of Dermatology and began to develop his active association with dermatology in 1911, and his professorship was given in 1936. The great developments of the clinical facilities at the Lakeside and City Hospitals were due to great energies of Dr. Cole and later his associates. In Columbus, Charles J. Shepard began his work at about that time and served his community and the Ohio State University for forty years.

(To be Concluded in November Issue)

KEEPING UP WITH MEDICINE

• CONFUSION still exists regarding the relationship of immunity to hypersensitivity. In the case of Brucellosis when hypersensitivity exists, the burden of proof rests on the physician to show that infection does not still exist.

* * *

• AT least 50 per cent of the adults suffering from asthma gave a history of its onset during childhood.

* * *

• BIG eaters not only ingest excess calories but also tend to choose diets too high in fat, sugar, and starch.

* * *

• THE intake of certain of the vitamins by the infant fed at the breast is considerably greater in the first few weeks than is usual in the case of the infant fed artificially.

* * *

• ALL seem agreed that improperly balanced diets, lack of adequate vitamins, metabolic disorders such as hypothyroidism and other endocrine deficiencies, insufficient sunlight and fresh air, climatic irregularities, local exposure to cold, faulty habits of living, breathing and exercising—all play a vital part in the child's susceptibility to both sinus infection and nasal allergy.

* * *

• ONE out of every five persons in this country suffers from some chronic disease.

* * *

• NO medical records of antiquity surpass the descriptions given by Hippocrates of pulmonary tuberculosis as it occurred in his day-to-day's work.

* * *

• PEOPLE of Europe emerged from the Middle Ages and came all the way down to the latter part of the last century with little comprehension of any principles of public health other than isolation and quarantine.

* * *

• THE clinical findings in cases of gold, arsenic, mercury, and thallium poisoning reveal lesions and patterns of lesions characteristic of a deficiency of vitamin factors.

* * *

• OVER 3.5 million persons in the United States suffer from Asthma and Hay-fever.

* * *

• IN the diabetic, the urine is to be collected before the next meal and the time when the type of insulin used is known to be exerting its maximum action. The bladder should be emptied 30 minutes to one hour before the urine to be tested is passed.—J. F.

Labor Looks at Prepaid Medical Care . . .

Frank Analysis of the Question by Harry Becker, Director of Social Security, U.A.W. in Talk Before Conference of Medical Officials

Editor's Note—The accompanying article is a transcript of an address made by Harry Becker, director, Social Security Department of the United Automobile Workers of America, at the 1950 Conference of Presidents and Other Officers of State Medical Associations in San Francisco, June 25.

Mr. Becker presents the views of organized labor on the question of prepaid medical care programs. Many readers of *The Journal* will, no doubt, disagree with some of the points made by Mr. Becker. Many of his criticisms can, no doubt, be refuted. However, in order to give its readers views on all sides of this popular subject, *The Journal* is reprinting Mr. Becker's talk, leaving it to them to draw their own conclusions.

PREPAID medical care is one of the major public policy questions before the American people today. Since it has become an issue of public policy, it has become a political issue—as it properly should. For in our democratic society the right to make political decisions on matters that concern all of us distinguishes our form of government from the kinds of government that exist today in many other parts of the world. There are now ten different bills dealing with health insurance before the Congress. Members from both sides of the aisle have signed these bills—some of which have bipartisan sponsorship. At least one out of every five senators has signed his name to one or more of these pending health insurance measures.

It is no cause for alarm that prepaid medical care has become a political issue.

In resolving this issue application of the democratic process is as fundamental as the decision that is reached. The physicians of America as well as the general public have a common stake in the free and honest application of our democratic process in solving this issue of prepaid medical care.

We are spending billions of dollars to protect our form of government and to demonstrate its meaning to other peoples of the world. It is futile to appropriate enormous sums of money for these purposes if we cannot resolve satisfactorily at home, within the social and political framework of our society, such questions as how to meet the people's need for medical care. Our answer to Communism is Democracy—not just the idea of democracy, but a demonstration of how it works to meet the needs of people. In this, organized labor and the physicians have a common interest and a common determination.

The demand for prepaid medical care grows out of recognition that the average family cannot pay for costly illness unless an insurance method for spreading the costs is developed. The working man knows that recommended treatment for himself and family often cannot be obtained because he cannot pay for it. Prepayment is the basic approach to removing this economic barrier.

COMMON INTEREST, DETERMINATION

A few decades ago the highest quality of medical care represented a very different standard from that available today in some of our modern medical institutions—as different as the model-T Ford is from the car of today.

Improved medical care standards are a part of the larger movement for higher standards of living. Higher standards are inevitable; they are part of the fight for human progress and a better life for all men. Higher standards of medical care for all people result from more knowledge and improved methods of distribution. The medical advances of the past ten years alone have changed patterns of practice and changed, likewise, our concepts of satisfactory standards of care. But these developments mean higher costs to the consumer.

The physicians of America have agreed that today's higher medical costs can best be met by some form of prepayment. The need for prepayment is not at issue; the issue, rather, is whether prepayment shall be accomplished through a system of public insurance or through a system of voluntary insurance augmented with governmental action.

Millions of dollars have been spent in the past several years by the American Medical Association and groups associated with it in the fight against national health insurance. The effect of this widespread and intensive program has been to promote public awareness of the insurance idea and the advantages of prepayment. The American Medical Association, there-

fore, deserves not-often-expressed credit for helping to "sell" health insurance to the American people and for making our Congress aware that certain national health problems do exist and that they exist as public issues. This awareness has been further stimulated by the Blue Cross and Blue Shield Plans and the commercial insurance companies in connection with their sales programs.

Organized labor and many physicians agree that the common objective is to bring the highest quality of medical care within reach of all people—that economic barriers to needed medical care must be lifted by a system of prepayment. From that point on, we have an area of controversy which will be resolved by Congress within the next few years.

DIFFER ON PREPAYMENT METHODS

It is to be expected that organized labor—that International Unions such as UAW-CIO—would have a position on this major issue. Likewise, we should expect the physician's organization—the American Medical Association—to have a point of view on the issue. When the mechanism for financing goods and services which the people need becomes a public issue, we can expect that the consumers and the providers of services may have somewhat different positions. Since workers are consumers of medical services and physicians are suppliers, it is not surprising that organized labor and the organized medical professions differ on the method of providing prepaid medical care.

Organized labor feels that the demand for health insurance should be met by a comprehensive national health program developed within the framework of our national health and social security policy. Such a national health program would represent a coordinated program for the following purposes: furthering medical research; building programs of preventive medicine; strengthening facilities for training professional personnel; aiding the establishment of hospital and clinic facilities in areas of special need; and establishing methods of prepaying personal medical care to assure adequate financing of the care needed by all members of our society.

GAP REMAINS

Labor's reasons for this position have been stated before. The methods of making medical care available and of paying for it have not kept pace with our technical know-how. There is a gap between the best that medical science and practice has to offer and that which is generally received by the people. We have not fully developed the vast potential for well-being and more healthful lives that is within our grasp. It is the desire to fill the gap between where we are and where we could be in bringing the best in medical care to the people that motivates labor to push for and support a comprehensive national health program.

A problem as complex as health insurance requires a synthesis of ideas from several different fields of thought and experience if we are to understand all of the factors involved. No one of us has within ourselves the resources to do this effectively and easily. Most of us expose ourselves to those journals and other mediums of communication peculiar to our own professions—neglecting the vital cross-fertilization that results from pulling together ideas from several schools of thought.

So it requires bringing together people who can add to our own fund of knowledge their experience and points of view. We will not always agree with these points of view; but only in this way can we have the opportunity to sift the truth from the untruth, the reasonable from the unreasonable and intelligently analyze the problem.

A physician makes an independent analysis before accepting the diagnosis of a colleague. To diagnosis the problems of prepaid medical care also requires tests and checks before independent judgment can be formed. Certainly a diagnosis of the economics of prepaid medical care should be checked and rechecked before being accepted. Too often diagnosis of this problem has been accepted without careful and analytical challenge.

REQUESTS UNPREJUDICED DIAGNOSIS

In view of this, we urge every physician in America to reanalyze the problem of prepaid medical care in the same objective and scientific manner that he would diagnose a new patient's medical problem.

Let us at this point prepare our prepaid medical care problem patient for surgery. Let us proceed with our surgery with the same care that we would exercise for a patient with an obscure disease that requires exploratory examination and subsequent treatment. If we are true medical scientists we will not be afraid to examine our patient thoroughly nor to take the necessary steps to accomplish the desired course of treatment.

The American Medical Association in its diagnosis says that governmental prepaid medical care is "Socialistic"; is inefficient; will lower the quality of medical care; and is too costly. To avoid these effects, the American Medical Association recommends that voluntary and nongovernmental agencies be the vehicle for provision of prepaid medical care.

The UAW-CIO and other unions currently negotiating for partial or fully-employer-paid hospital and medical protection for their members and their families are having an opportunity

to learn the extent that voluntary agencies are unable to provide prepaid medical care. Through collective bargaining, UAW-CIO has won this year employer contributions toward the cost of prepaid medical care for over half a million families. This number will soon reach a million in our Union; and the total number of workers in America for whom such gains are won in collective bargaining will soon reach five to eight million.

CHOICES AVAILABLE

Let us examine labor's nation-wide experience in its efforts to provide under collective bargaining agreements prepaid medical care through existing voluntary agencies.

The choices available to labor today for programs developed under collective bargaining are:

1. To utilize the commercial insurance company plans with their cash indemnity approach.
2. To participate in Blue Shield Plans sponsored by the state medical societies.
3. To establish Union-operated clinics and hospitals.
4. To promote and use such organizations as the Health Insurance Plan of Greater New York, the Group Health Association of Washington, D. C.; or to make agreements directly with physicians in group medical practice or with hospitals with salaried physicians.

The American Medical Association Council on Medical Services has not taken a position in support of the medical society-sponsored plans as the preferred agency. The Council gives equal weight to the commercial insurance company and the Blue Shield Plan approach. We do not understand why non-profit prepayment plans sponsored by the state medical societies are not favored by the Council on Medical Services. Neither do we understand why the Council does not recommend the consumer-sponsored group medical practice type of plan in preference to the insurance company plans.

COMMERCIAL INSURANCE PLANS

The commercial insurance company prepaid medical plans fail to meet the standards for prepaid medical care implied by the American Medical Association in its criticism of national health insurance proposals. The insurance companies at best provide only cash benefits with payments depending on the surgical procedure or other service performed. These cash benefits bear no direct relation to the cost to the worker of his medical care. Nor do they bear a proper relation to the kind of care for which his physician or physicians should be reimbursed. Thus, they meet neither the workers' nor the physicians' needs for prepaid medical care.

Insurance companies provide an expensive method of prepaid medical care because of high operating expenses. For group insurance the operating cost is measured by the amount of premium dollar allocated for selling, profit, administration and taxes. On the average this is about 20 cents on each premimum dollar. Often it is as much as 40 cents.

Benefits under commercial insurance company plans are inadequate when measured by the degree of protection afforded to the worker and his family. Experience with the cash allowance approach to prepaid medical care indicates that in many instances the existence of the insurance is interpreted by the physician as increasing the worker's ability to pay for care. Therefore, his fee is larger than it might have been had the benefit not been available—and the worker must pay the extra amount.

Another point that should be made with respect to this approach to prepaid medical care is that within this framework there can be no recognition of quality of care nor does it promise flexibility for development of comprehensive services. In fact, the question might be asked whether or not cash allowances for surgical procedures do not sometimes encourage unnecessary surgery.

We cannot recommend to our members the commercial insurance company approach as a satisfactory method of providing prepaid medical care under collective bargaining contracts. Since the insurance company plans do not satisfy the American Medical Association's own criticism on many prepaid medical plans we sometimes wonder if the support by the American Medical Association of this approach does not indicate that approval is being given to the insurance company plans in exchange for their opposition to national health insurance rather than on the merit of their programs.

BLUE SHIELD PLANS

Organized labor, in setting up programs under collective bargaining, has found that the Blue Shield Plans—like the commercial insurance company plans—fall far short of meeting requirements for prepaid medical care programs when measured by the yardstick used by the American Medical Association in evaluating national health insurance proposals.

We must realize, when we evaluate the Blue Shield Plans, that they are relatively new, and have not had time to mature. At the same time we must realize that if they are to be utilized as a method of prepayment for medical care under labor-management contracts they have a job to do that has not been done. The present Blue Shield Plans are not satisfactory to labor groups which are making health insurance an issue in negotiations with employers; nor are

they satisfactory to many management officials with whom labor negotiates for health insurance.

INADEQUACIES

Specifically, our experience with Blue Shield Plans has demonstrated the following inadequacies:

1. They do not provide real security to the worker against the economic consequences of illness. The reasons are two-fold: first, the Blue Shield Plans are limited in scope and generally subscribers have only protection against the cost of surgery; second, the worker has no assurance, when he or members of his family are ill, that the Blue Shield allowances will meet the full cost of surgical or other types of care; and further, the cash indemnity benefits bear little relationship to the charges made by physicians or to the amount of services rendered.

Blue Shield cannot be the prepayment plan of choice for programs set up under collective bargaining unles the worker can be assured that when he obtains Blue Shield coverage he is given adequate health insuranc protection against the costs of medical care. The worker wants security against the cost of illness in the same manner that he wants security against the time when he will be too old to work and too young to die.

The Blue Shield Plans can meet the objection that benefits provided are not full-payment for physicians' services rendered by removing the income ceilings entirely, or at least by raising them to a level which will assure workers that when illness strikes the full cost of care will be met through the prepayment plan. This would require a family income ceiling of at least $5,000 rather than the present prevailing ceilings of from $2,500 to $3,000. And this income ceiling should be raised without increasing fees and rates to a level that is prohibitive. In most instances any increase in fees should be minor in character to permit elective adjustment of specific fees, and not across the board increases.

EXPENSES

2. In general, Blue Shield plans are too expensive for the protection provided, because operating costs are still too high. In 1948 the average Blue Shield Plan spent somewhat less than 15 per cent of total income for operating expenses. Some Blue Shield Plans have an operating expense more favorable than the national average. Others have operating expense records of one-fourth and more of income. This is too high for a successful prepaid medical care plan.

Also, Blue Shield Plans, to be successful in competing cost-wise with other types of prepaid medical programs, must experiment with methods of paying physicians, including methods of paying for group medical practice and out-patient clinic service.

QUALITY OF CARE

3. We feel that medical insurance plans should maintain and promote incentives for improving the quality of medical care. One of the major American Medical Association criticisms of national health insurance is that it believes the quality of care would be lowered. But the voluntary Blue Shield Plans have done practically nothing to improve the general level of medical care, even though much can be done. In fact, some Blue Shield Plans are specifically prohibited from being concerned with any aspect of the quality of care.

If medical review and study were given to various aspects of the Blue Shield program, such as studies of doctor's bills and the procedures performed, a necessary public service could be rendered. Group medical practice can be encouraged by the Blue Shield Plans as a measure for improvement of quality of care. There are inumerable examples of how an organized prepaid medical program sponsored by the medical profession could take positive action within the framework of acceptable medical ethics to raise the general level of medical care.

NON-SURGICAL AS WELL

4. Organized labor and most, if not all, management groups want a health insurance plan that is concerned with building a program which removes the economic hazard of non-surgical as well as surgical illnesses and chronic disease, and which also builds toward prepayment for integrated preventive and treatment programs. However, with but one or two exceptions, the Blue Shield Plans have done nothing about such major problems as heart disease, cancer, rheumatic fever, diabetes, tuberculosis, burns, osteomyelitis, severe fractures and other types of chronic or prolonged illnesses that can be more costly to the worker and his family than a hospital admission for a surgical procedure. These types of chronic illnesses are even greater economic burdens to the worker than the type of medical care now covered by many Blue Shield Plans.

The Blue Shield Plans have failed completely to build toward programs of comprehensive medical and surgical coverage for the full range of medical services, including preventive services, for which prepaid medical care is needed. Where integrated and coordinated community services for adequate care of certain types of illness are lacking the Blue Shield Plans have not taken initiative in working with the medical and hospital groups for the providing of programs that the Plan administrators and Boards of Trustees know to be desirable. The Blue

Shield Plans have not done as good a job of health education as some of the insurance companies. The Blue Shield Plans have not accepted their responsibility to join forces with others in the medical community in building improved city-wide and state-wide medical care services.

Success of voluntary prepaid medical care plans should not be measured alone by the number of subscribers. It is impressive to show the growth of these plans in terms of the number of subscribers. It is significant that 14 million Americans have Blue Shield coverage—but the gap between the type of program that is provided and what is needed is even more significant. We must keep an eye on how rapidly and how adequately we are meeting the real needs of the people.

Generally speaking the Blue Shield Plans are not giving the public much more than the insurance companies, and in some cases not as much. This is a serious charge.

The medical profession has a great responsibility in this matter if the voluntary plans are going to meet the objectives of health insurance programs set up under collective bargaining agreements. The medical profession society plan has been given a virtual monopoly as the only non-profit prepaid medical care plan. The kind of monopoly that Blue Shield enjoys requires a high degree of social and community responsiblity.

UNION AND CONSUMER-SPONSORED PREPAID PLANS

UAW-CIO, for example, feels money obtained through collective bargaining for hospital care should be utilized to strengthen the hospital facilities and services for the entire community and not just for one segment in the community. Hospital and medical programs made possible under collective bargaining contracts should be developed in a manner that will strengthen the total community prepaid hospital and medical care program as well as facilities for care. In those cities where most workers are assured prepaid medical protection under collective bargaining programs the money available because of these programs will result in higher standards of hospital care and a greater number of hospital beds. Removal, for the patient and the physician, of the economic barriers to the kind and amount of medical care required will mean higher standards of care for the workers and for all members of the community.

To the extent that existing prepaid medical plans do not provide the kind of protection and types of programs that are necessary for a health insurance plan, Unions will have to make agreements directly with hospitals and groups of physicians. In large cities, if presently available prepaid medical care plans are not prepared to move in the broader aspects of the voluntary prepaid medical care job in connection with collective bargaining programs the New York Health Insurance Plan pattern may be an answer. In smaller cites, the group medical practice pre-payment plans built around one or two local hospitals may be a solution for the collective bargaining programs.

In sharing with you our criticisms of the existing voluntary prepaid medical care plans which result from our experience with collective bargaining programs, we realize that many representatives of the medical profession will not agree with all our objections. We believe, however, that our experience is a valid test of what is available today in relation to the desires of our Union and many other Unions. Even though we recognize that prepaid medical care program set up under collective bargaining agreements cannot substitute for a health insurance program covering the entire population, some of the gaps in our collective bargaining programs can be filled by cooperative planning between the Unions and the plan administrators. We should fill some of these gaps.

We cannot talk about collective bargaining programs that require joint planning between ourselves and representatives of the medical profession if they are to be fully effective in meeting their objectives without pointing out that there are serious barriers in the way. The practicing physician must wonder why there exists a feeling of mistrust and misunderstanding between the physicians and such consumer groups as organized labor. It is unfortunate that this situation exists because it impedes progress. But it does exist and something should be said and done about it.

UNITY LACKING

An example of the medical profession's lack of real support of voluntary prepaid health programs is the great difficulties experienced by Blue Cross in establishing national standards of hospital protection to assure full-payment for hospitalized illness. A few months ago one state medical society adopted a resolution in opposition to Blue Cross efforts to establish a standard in that state which would enable Blue Cross to say to its subscribers that its contract would pay the full amount of the hospital bill. Further, when this resolution was passed there was no other recommendation as to how this desirable objective should be accomplished by Blue Cross. How does this medical society expect voluntary plans to provide a comprehensive prepaid hospital plan? Another example of the medical societies unwillingness to provide effective prepaid medical plans is their recent refusal in a number of states to increase the income ceilings.

Another reason for Labor's mistrust of the

motives of the American Medical Association is the type of publicity it has engaged in. Millions of dollars have been spent to advance the reasons why national health insurance, in the judgment of the American Medical Association, is not a desired method for meeting the existing prepaid medical care problem. The American Medical Association in a recent folder entitled "The American Way is the Voluntary Way" states that the only question is: "How will you have your health insurance: On a voluntary basis—with sound medical direction? Or a compulsory basis—with politicians at the controls?" Then the folder proceeds to set forth 50 questions and answers. In many cases the answers are factually incorrect and, for the most part, the language which is used is intended not to give an understanding of the problem, but to frighten doctors and others into political action in support of the official American Medical Association position.

For example, the statement is made that Lenin said: "Socialized medicine is the keystone to the arch of the Socialist State." The Library of Congress has been unable to find any evidence that Lenin ever made such a statement. The leaflet follows this unsubstantiated statement with the accusation that those who support national health insurance are supporting Lenin's concept of a Socialist State. This is, of course, untrue, as is made obvious by Labor's fight against Communism.

Labor is aware that hundreds of thousands of such folders are being distributed while at the same time there is no evidence that organized medicine is making any comparable efforts to meet and solve the problems which are forcing the people to reject the voluntary plans as a substitute for a national health insurance program.

DEPLORES 'ROAD AHEAD'

Labor is also concerned because the American Medical Association has expended much effort and money in the past few months to distribute a book of half truths and scare words that is as dangerous a threat to our form of society as any piece of literature or activity of the Communist Party. This reactionary, undemocratic book, "The Road Ahead" by John T. Flynn, was reviewed in the *New York Times* as "The latest manifestation of an endemic hysteria presently affecting a considerable segment of our society."

Even if the doctors of America were unaware of the judgment of responsible reviewers of this book they should be alarmed at being associated with the kinds of groups that are asking the American Medical Association to finance its distribution. For example, the Committee for Constitutional Government, which circularized the doctors of America urging them to buy it in quantity for their friends and patients, stands for much that would make most physicians cringe with embarrassment. It was reported in the *Washington Post* a few days ago that a million and a half copies of this book have been bought and distributed by the medical profession. This statement may or may not be precisely correct. The exact number of copies distributed is relatively unimportant. What is striking is that organized medicine would distribute such a book and expect to have our confidence.

It is fair, certainly, to ask what would have been the effect had the energy and money which went into distribution of this book gone into constructive effort to improve prepaid medical care plans.

There are other reasons why organized labor questions the social responsibility of the American Medical Association and why there is misunderstanding between these two groups. One is the American Medical Association's opposition to the inclusion in the Federal Social Security program of cash income payments for persons who are unable to work because of permanent and total disability. Labor is concerned about the need for retirement security for disabled persons as much as it is for the aged.

Employers have almost without exception recognized the need for incapacity retirement as well as age retirement and both types of pensions have been provided for in collective bargaining agreements negotiated this past year.

DISABILITY IN SOCIAL SECURITY

The House of Representatives recognized this need when it passed H. R. 6000—the Bill amending the Federal Social Security Act—with a provision for retirement benefits for insured workers who are unable to work because of permanent and total disability. Labor began to feel that at last there was general acceptance of the obvious need of disabled workers. But when hearings were held in the Senate early this year the American Medical Association and the insurance companies led the opposition to disability benefits.

Reasons for the opposition of the insurance companies were obvious—a public disability insurance program would, they feared, reduce the volume of sales for disability insurance. Reasons for the American Medical Association opposition to this type of income maintenance protection are not so clear.

We made a direct appeal to the American Medical Association to support this provision for the disabled or at least to withhold opposition. Labor had reason to feel that organized medicine would not fight this type of social security because in the October 11, 1947, issue of *The Journal of the American Medical*

Association it was stated editorially that "Social security measures to maintain income such as disability insurance, old age insurance and public assistance are likewise of vital importance." This editorial comment followed earlier action of the House of Delegates of the American Medical Association favoring disability insurance.

But we were disappointed.

In testimony before the Senate Committee on February 28, 1950, the official spokesman for the American Medical Association said his organization was opposed to the permanent and total disability benefit because it might lead to Congressional consideration at some future time of health insurance or some form of government medicine for this category of individuals. He suggested that the permanently disabled should look to local poor relief authorities for any assistance they might need. Local poor relief payment per family unit for the month in which this statement was made was only $48.71.

Labor will not soon forget that the entire resources of the American Medical Association were thrown into the fight to oppose giving the permanently and totally disabled the same kind of protection that is now given the unemployed and the aged.

It would seem obvious that if the voluntary health insurance approach is so vulnerable that an extension of cash income benefits to the permanently and totally disabled is a serious threat, the voluntary plans must not be as valid an alternative to national health insurance as many believe.

TWO MAIN PROBLEMS

When we look at prepaid medical care there are two main problems that come to mind: (1) How can we give all people prepaid comprehensive medical protection, and (2) what can we do to make higher standards of care generally available? Neither of these tasks is simple and neither can be accomplished quickly. But we are going to have to solve them.

Progress toward these objectives will not be made on a constructive basis until there is the kind of understanding which permits the workers in the shops and on the farms and the physicians of America to work together. For the successful planning and administration of prepaid medical care programs requires the teamwork of the physicians who provide the care and the people who pay the costs. This is a reason why voluntary prepaid medical plans should have more public representatives selected from among the subscribers on the Boards of trustees.

Sometime and somehow—but soon— we will find a way to work together to lift the economic barriers so that the highest quality of medical care will be available to all people regardless of their race, where they live or their economic status.

The historian will record how well we meet this challenging opportunity for a constructive demonstration of democracy at work. We must remember, in today's war of ideas, that our ability to work together here in America is vital if we are going to build hope and inspiration in the hearts of all people wherever they may live.

Veteran Patients To Military Hospitals Limited

The Department of Defense and the Veterans Administration announced that, following conferences between officials of the two agencies, the Veterans Administration will discontinue sending Veterans Administration patients to the majority of military hospitals in continental United States, except in emergencies. This has been necessitated by the increasing requirements for medical personnel in the Korean military operation, the flow of military casualties from that area to the United States, and the rapid expansion of military forces in this country.

Army hospitals will continue to care for those veteran patients now hospitalized; it is expected, however, that normal attrition through discharge of these patients upon completion of treatment will remove practically all of these patients from the majority of Army hospitals within about six weeks.

Currently, the Veterans Administration is operating 138 hospitals with approximately 114,000 beds. During 1950, twelve more Veterans Administration hospitals are scheduled to be opened, adding more than 3,000 beds to the Veterans Administration present capacity.

Exception has been made of the Tuberculosis beds at Fitzsimons General Hospital, where Veterans Administration has 325 Tuberculosis patients.

Opinion of Attorney General

The syllabus of Opinion No. 1871 of Attorney General Herbert S. Duffy is as follows: "(1) Paying the hospital bill of a girl or woman may or may not be a 'social service' within the purview of Section 3070-17, subsection (e), of the General Code, depending upon the facts and circumstances of the particular case involved. (2) The language 'girl or woman' as used in Section 3070-17, subsection (e), of the General Code, refers to any female person regardless of age."

Section 3070-17 of the General Code defines the duties and powers of a Child Welfare Board. The subsection referred to reads: "(e) To provide social service to any girl or woman who is pregnant with or who has been delivered of an illegitimate child."

Medical Schools Set Enrollment Record; More Doctors Graduated

The outlook for graduation of more doctors to safeguard the health of the American people is better than it has ever been. This is brought out in the annual report of the American Medical Association's Council on Medical Education and Hospitals, published in the September 9 issue of *The Journal of the A.M.A.*

All records for enrollment in approved medical schools in the United States were broken in the past year, the report revealed.

Total enrollment in the 72 medical and seven basic science schools for the academic year 1949 - 1950 was 25,103. This represents an increase of 1,433 students, or six per cent over the preceding year. The total is double the enrollment in 1910 (12,530), about 18 per cent higher than 10 years ago, and even larger than during the years of World War II, when extra classes were enrolled in all medical schools on an accelerated program.

From July 1, 1949, to June 30, 1950, 5,553 physicians were graduated from approved medical schools in the U. S., an increase of 459 over the preceding year. This is the largest number graduating from approved medical schools in the nation in one year except for the year 1946 and 1947 when several schools at the conclusion of their wartime programs graduated more than one class during a 12-months' period.

HIGHER THIS YEAR

On the basis of their enrollments in the senior class for 1950 - 1951, the medical schools have estimated that they will have slightly more than 6,000 graduates during the coming year.

The freshman class for the first time exceeded 7,000 students during 1949 - 1950. The actual number, 7,042, represented an increase of 354 or 5.3 per cent over the preceding year and an increase of 1,026 or 17 per cent over the average size of the freshman class in the 10 years preceding World War II. On the basis of records of the past, it seems likely that within the next few years the freshman class will number close to 7,500 students.

The report said that the budgets of the medical schools and basic science schools for the 1950 - 1951 fiscal year total about $67,500,000, representing an increase of about 42 per cent in the last four years. It also said that about $100,000,000 worth of new construction had been reported—which is estimated as only about half of construction completed, started, or authorized during the last year.

Women totaled 1,806 or 7.2 per cent of medical students, compared to 2,109 or 8.9 per cent in the preceding year. The percentage of veterans enrolled in the medical schools and schools of basic medical sciences was 65.9 per cent—about the same as the preceding year.

Polls taken in 19 medical schools during the past year reveal that the percentage of students planning to enter general practice has increased from 36 to 47 per cent in the last three years. The number planning to specialize has decreased from 36 to 31 per cent. Other students polled in both periods still had to make decisions.

EMERGENCY PLANS

The problem of formulating a sound program for medical education in the event of another world war has been under study by the Council on Medical Education and Hospitals. The Council and the Executive Council of the Association of American Medical Colleges have formed a joint committee on medical education in time of national emergency.

This committee has been engaged since June in drafting for submission to the appropriate government agencies recommendations with respect to the conduct of medical education, including premedical and graduate medical education.

Second District Meeting Scheduled In Dayton, October 18

An afternoon and evening program will be conducted by the Second District of the Ohio State Medical Association at the Biltmore Hotel in Dayton on Wednesday, October 18. Members of Societies outside of the Second District also are invited.

A noon luncheon will be held at the Biltmore Hotel for members of the Auxiliary.

At 2 p.m. the subject, "The Use of Radioactive Isotopes in Medicine," will be discussed. On the panel are the following members of the Montgomery County Medical Society: Drs. Darrel C. Caudill, William H. Fries, George A. Nicoll, Franklin L. Shiveley, Jr., and Robert E. Zipf.

To tie in with the discussion, the Monsanto Laboratories of Dayton have been building for weeks an original exhibit and demonstration to be presented for the first time at the session.

At 3:30 p.m., Dr. Allan C. Barnes, professor and head of the Department of Obstetrics and Gynecology, Ohio State University College of Medicine, will discuss, "The Use of Radioactive Cobalt in the Treatment of Cancer of the Cervix."

A social hour for physicians and their wives will be held from 5:30 to 6 p.m., followed by the annual banquet at 6:30. The speaker of the evening will be The Honorable Clarence J. Brown, Blanchester, Representative of the Seventh Congressional District, who will speak on the subject, "What's Going on in Washington."

Reservations for the banquet are $5 each, with the ladies as invited guests.

What You Can Do . . . Should Do .

BETWEEN NOW AND NOVEMBER 7 . . .

Every Ohio physician . . . members of his family . . . must stand up and be counted . . . must join the ranks of thousands of Ohioans who are already working day and night to elect competent, qualified candidates to public office . . . Many physicians and their wives are taking an active part now in pre-Election activities . . . but not enough of them.

BETWEEN NOW AND NOVEMBER 7 . . .

Ohio physicians and members of their families must work for . . . get others to work for . . . those candidates who support sound social, economic and governmental principles. Physicians are being subjected to vicious attacks by certain politicians and leaders of various radical groups. The chips are down. The issues are vital. PHYSICIANS DARE NOT BE SLACKERS IN THE CURRENT ELECTION BATTLES.

BETWEEN NOW AND NOVEMBER 7 . . .

Ohio physicians should secure from the officers and legislative chairman of their LOCAL MEDICAL SOCIETY information and advice regarding all candidates on the ballot at the General Election . . . should submit additional information to them regarding candidates . . . should pass on to patients, neighbors and acquaintances, information regarding candidates . . . should urge the support of candidates worthy of public confidence.

BETWEEN NOW AND NOVEMBER 7 . . .

Ohio physicians should contact candidates they intend to support . . . should offer active support . . . should carry on an active personal letter-writing campaign for such candidates . . . should make use of the telephone and personal appeals to get others to support such candidates. SUPPORT AND VOTES OF JUST PHYSICIANS WILL NOT BE SUFFICIENT . . . The support and votes of many others will be necessary to elect the qualified candidates.

BETWEEN NOW AND NOVEMBER 7 . . .

The wives and daughters of physicians . . . members of the Woman's Auxiliary . . . can and should play an important part in winning active support for qualified candidates among physicians . . . members of their families . . . and citizens generally. After securing accurate information about candidates from the officials of the local medical society they can carry on an active telephone, letter-writing and door-to-door campaign to win votes for such candidates.

BETWEEN NOW AND NOVEMBER 7 . . .

Physicians who change their places of residence should see their county board of elections about transferring to the poll list of their new precinct . . . Physicians

. Between Now and November 7

who know that they are going to be away from home on Election Day should see their county board of elections about voting by absentee voter's ballot . . . Physicians who have patients who, because of illness, probably will be unable to go to the polls on Election Day should assist such patients in securing from the board of elections ballots for voting by mail . . . Physicians who have relatives or friends in the armed services should assist them in voting by mail by getting information and papers for them from the board of elections . . . Accurate information on these procedures can be obtained from each county board of elections.

BETWEEN NOW AND NOVEMBER 7 . . .

Physicians and members of their families can become active affiliates of clubs, committees and organizations which have been formed by or on behalf of many of the qualified candidates to carry on an organized pre-election campaign. These groups have planned programs . . . they need volunteers for their door-to-door, block-by-block activities and letter-writing, telephone-calling programs.

BETWEEN NOW AND NOVEMBER 7 . . .

Each County Medical Society in Ohio should devote a meeting during October to a discussion of candidates . . . how to get data on candidates into the hands of members . . . what physicians as individuals can do for deserving candidates . . . how physicians can help to get the sick and disabled to vote by mail or can help in securing transportation for them on Election Day. No other subject for a county society meeting is of greater importance at this time.

ON NOVEMBER 7 . . .

Every Ohio physician and voting members of his family should go to polls . . . Physicians should see that their employes vote . . . are given sufficient time-off to go to the polls . . . Wives of physicians should phone neighbors and friends for the purpose of seeing that they have voted or are planning to go to the polls . . . Physicians and members of their families should provide transportation for relatives, friends, neighbors and patients who find it difficult to get to the polls or make their automobiles available to organized transportation committees . . . Physicians and members of their families should offer their services to committees set up to canvass the polling places during Election Day . . . to get in touch with those who fail to show up.

ON NOVEMBER 7 . . .

The fight for good government will be won or lost. Votes will decide the issue. Your vote could well be the deciding vote. Now is the time to get in the fight . . . to see that the people of your community understand the issues . . . are informed about the candidates . . . are determined to cast their votes as their conscience and judgment dictate.

Licenses Granted . . .

State Medical Board Authorizes 262 Graduates of Medical Schools To Practice in This State Following June Examinations in Columbus

CERTIFICATES to practice medicine and surgery in Ohio were authorized for 262 graduates of schools of medicine by the State Medical Board at its meeting on August 8, Dr. H. M. Platter, secretary, announced. The licenses are being granted as the result of examinations given by the board in Columbus, June 14-17.

Highest grade in the examinations was made by Robert C. Sheahan, of Columbus, a graduate of the Ohio State University College of Medicine. His grade was 90.6 per cent.

A close second of 90.5 per cent was made by Charles H. McMullen, of Cincinnati, also a graduate of Ohio State.

The third highest grade of 89.5 per cent went to Robert J. Bosley, Cleveland, a graduate of Western Reserve University School of Medicine.

Ten graduates of Osteopathic schools were authorized to practice osteopathic medicine and surgery, and one applicant who appeared for additional examinations will receive a certificate to practice osteopathic medicine and surgery.

In the limited branches, certificates will be awarded to 31 chiropodists, 14 mechanotherapists, 10 chiropractors, 17 masseurs and six cosmetic therapists.

Graduates of medical schools who will receive certificates to practice medicine and surgery are the following:

OHIO STATE UNIVERSITY COLLEGE OF MEDICINE: John L. Babb, Jr., Meriden, Minn.; William L. Berson, Newark; Michael C. Bianco, Akron; William R. Blesch, Columbus; John D. Bloom, Miami, Fla.; Charles E. Bope, Columbus; Roscoe C. Brand, Jr., Fort Sam Houston, Texas; William E. Brown, Marysville.

William H. Campbell, Toronto, Ohio; Doris N. Carson, Carrollton; Bennie W. Chiles, New York; George G. Cornish, Cleveland; Charles V. Cox, Chagrin Falls; David J. Crosby, Cleveland; John R. Daniels, Columbus;

Thomas M. Faehnle, Columbus; George H. Freetage, Columbus; Bernard Glass, Youngstown; Thomas W. Graham, Berea; Oren B. Gum, Denver, Colo.; John W. Heffelfinger, Columbus; Lester E. Imboden, Logan; Dean H. Johnson, Lancaster; Richard E. Jones, Columbus;

William A. Kelemen, Youngstown; Marvin I. Kohn, Cleveland Heights; Robert Levine, Columbus; Charles W. Loughry, Columbus; John D. Lovett, Columbus; Lloyd K. Mark, Columbus;

James E. Matson, Maynard; James H. McClure, Columbus; Charles H. McMullen, Cincinnati; Saul L. Meyers, Columbus; Gordon L. Miles, Indianapolis, Ind.; George F. Millay, Columbus; Marvin L. Mitchell, Toledo; Paul N. Montalto, Columbus;

John H. Nickel, Warren; Gordon F. Ogram, Detroit, Mich.; David W. Parke, Columbus; Frank G. Plymire, Wilmington; John R. Polsley, Columbus; Thomas M. Prescott, Columbus;

Jack M. Randall, Dayton; Richard W. Reiman, Dayton; Lucille Richardson, Columbus; James R. Romaker, Lima; Alfred G. Runner, Huron;

Marvin J. Sakol, Denver, Colo.; Richard E. Sand, Columbus; Morton Sass, Cleveland; Richard A. Schroeder, Cleveland; William R. Shaw, Pemberville; Robert C. Sheahan, Columbus; William G. Simonis, Tiffin; Arthur I. Stecker, Cleveland; Byron Stinson, New Holland;

Miller F. Toombs, Columbus; Jewell E. Van DeWater, Columbus; George Van Harlingen, Dayton; Carol Dewey Varner, Columbus;

James M. Walters, Dayton; Anna Stahly Whetstone, Columbus; John K. Williams, Toledo; Edwin C. Winzeler, Toledo; John Worthman, Dayton; William V. Zartman, Columbus:

UNIVERSITY OF CINCINNATI COLLEGE OF MEDICINE: Ferdinand J. Ach, Cincinnati; Mary Allott Agna, Cincinnati; Arnold C. Anderson, Rhame, North Dakota;

Rolland D. Bateman, Jr., Cincinnati; John C. Bauer, Defiance; Frank L. Baynes, West Lafayette, Ind.; Carl P. Bernet, Jr., Cincinnati; Robert T. Blair, Goshen; Thomas L. Bogardus, Jr., Cincinnati; Otis E. Bridgeford, Cincinnati; Leonard A. Burgin, Cincinnati; Robert L. Burket, Sandusky;

Vincent J. Cannamela, Perth Amboy, N. J.; Joseph M. Casper, Denver, Colo.; Leon G. Claassen, Denver, Colo.; Mary M. Clift, Cincinnati; Robert P. Cook, Ionia, Mich.; John S. Cunnick, Norwood;

Melvin N. Davis, Toledo; George R. DeMuth, Sherwood; Mark S. Dine, Cincinnati; Donald L. Domer, Cincinnati; Roy L. Donnerberg, Sharonville; John R. Donohoo, Georgetown; William C. Duffey, Cincinnati;

Howard H. Feigelson, Cincinnati; Richard S. Flatt, Cincinnati; William M. Follis, Lansing, Mich.; Carl H. Hall, Dayton; Frank R. Hanzel, Barberton; Andrew H. Henderson, Jr., Cincinnati; James C. Hetherington, Cincinnati; Walter R. Herron, Lawrenceburg, Ind.; James C. Hertel,

Lockland; David J. Hickson, Cleveland; Paul R. Hummell, Brice;

John R. Keys, Cincinnati; Ralph H. Klingenberg, Cincinnati; William J. Kopp, Cincinnati; Robert E. Krone, Cincinnati; Francis X. Lothschuetz, Springfield;

James R. Mathews, Cincinnati; Leo C. McCampbell, Whiting, Ind.; Robert H. McMaster, Gallipolis; John N. Meagher, Springfield; Myron R. Melamed, Cleveland Heights; James R. Merkel, Cincinnati; Frank X. Mohaupt, Cincinnati; Gwendolyn L. Morris, Akron;

David I. Olch, Dayton; James W. Passino, Battle Creek, Mich.; James M. Pierce, Jr., Cincinnati; Charles L. Preston, Paintsville, Ky.; William R. Puttmann, Cincinnati; Henry E. Rasmussen-Taxdal, St. Petersburg, Fla.; Mary Clore Readle, Cincinnati; Betty L. Wilmas Robinson, Cincinnati;

Jasper E. Sadler, Jr., Cincinnati; Richard B. Salzer, Cincinnati; Frank J. Schrader, Warren; Bernard Sisman, Youngstown; Joseph G. Springer, Dayton; William J. Stiles, St. Bernard; Charles E. Stilgenbauer, Lima; James B. Street, Cincinnati; Laymond A. Swinehart, Warren;

Ingeborg P. Thuss, Cincinnati; Robert L. Tour, Cincinnati; Eugene R. Turner, Middletown; James W. Vaughn, Cincinnati; Marvin L. Whitman, Warren;

Glenn L. Winkle, St. Bernard; Frederick A. Wolf, Cincinnati; Emily E. Wright, Washington, D. C.; Yutaka K. Yoshida, Honolulu.

WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE: William H. Allen, Jr., Parma; Walter D. Anderson, Des Moines, Iowa; James P. Andrews, Akron; Morton L. Angell, Shaker Heights;

Jackson N. Bales, Euclid; Gilbert H. Barnes, Cleveland; Frank M. Barnwell, Cuyahoga Falls; Mary N. Barrington Michael, Cleveland; Harry Bauer, Cleveland; Soll Berl, Brooklyn, N. Y.; William F. Birskovich, E. Cleveland; Robert J. Bosley, Cleveland; Malcolm A. Brahms, Shaker Heights; Benjamin B. Brussel, New Haven, Conn.;

Frederic E. Caldwell, Cleveland; Lois Jones Carter, Cleveland; Hilda B. Case, New York; Charles E. Casto, Akron; Harry T. Cerha, San Antonio, Texas; Kennard T. Chandler, Cleveland Hts.; Jean E. Cram Cline, Cleveland; Theodore N. Cline, Cleveland; Miguel A. Colon-Morales, Arecibo, Puerto Rico;

William H. Dillon, Cleveland; Marion E. Erlandson, Shaker Heights; Henry A. Essex, Cleveland; George F. Feil, Cleveland; Julius Fishman, University Heights;

Charles N. Giering, Poland, Ohio; Eli Gold, Cleveland; Belden D. Goldman, Cleveland; Fairfield Goodale, Jr., Cambridge, Mass.; Edward E. Grable, Canton; Arthur E. Grant, Denver, Colo.;

Donald R. Hales, Cleveland; Earl E. Hellerstein, Cleveland; James E. Henderson, Denver, Colo.; Martin Hurvitz, Mineola, Long Island, N. Y.; Albert N. Kleinman, Cleveland Heights; Mortimer V. Kleinmann, Jr., Cleveland;

Grant A. Leiby, Jr., Parma; Edward T. Lis, York, Pa.; James W. Loney, Cleveland; James A. MacKay, Toledo; Richard A. Mahrer, Cleveland; Walter S. McCleery, Jr., San Francisco, Calif.; Jean G. Nau McClelland, Cleveland Heights; John Gibson McClelland, Cleveland Heights; James A. McEachen, Jr., Cleveland; Felix A. McParland, Jr., Shadyside;

Clarence N. Melampy, Mason; Frank B. Metting, Wadsworth; Richard R. Neitz, Wellsville; Evelyn J. Nelson, Cuyahoga Falls; Robert C. Nelson, Berkeley, Calif.; William B. Newberry, Jr., Cleveland Heights; John H. Neyer, Cleveland;

Virginia L. Owen, Valley Stream, N. Y.; Sam Packer, Cleveland; John D. Petcher, Cleveland; Evelyn Richardson Peters, Cleveland; Lawrence Peters, Cleveland; Fred M. Rankin, Jr., Akron; Robert E. L. Rochelle, Cleveland Heights; Herbert B. Rosenbaum, Cleveland;

Russell L. Shafer, Weston, Mass.; John S. Schlecht, Cleveland; John L. Schmidt, Cleveland; Albert G. Schraff, Cleveland; Herman Schreiber, Jr., Newport, R. I.;

Samuel R. Schuster, Baltimore, Md.; Franklin R. Shaft, Cleveland; Henry L. Shorr, Youngstown; John A. Spargo, Cleveland; Anthony F. Spech, Cleveland; Gerald H. Strate, Cleveland;

Donald L. Toker, Cleveland; Robert J. Trautman, Baltimore, Md.; Irvin Ungar, Cleveland Heights; John W. Unger, Alliance; Eugene W. Veverka, Cleveland; Walter W. Vogt, Akron;

Gertrude E. Warner, Schenectady, N. Y.; Mary A. Weidle, Hartford, Conn.; Robert J. E. Westhart, Chicago, Ill.; Wallace G. Wheeler, Norwood, Pa.; John V. Wilber, Cuyahoga Falls; David Wladis, Cleveland; Martha Bieler Wysor, Cleveland.

GRADUATES OF OTHER SCHOOLS: Bowman Gray School—Gordon W. Hayslip, Columbus.

Chicago Medical School—Herbert S. Lipschultz, Columbus.

Cornell University—David H. Williams, Cleveland.

George Washington University—James L. Goddard, Kalida.

Harvard Medical School—Robert E. Eckel, Cleveland.

Jefferson—John R. Titus, Columbus.

Johns Hopkins—Edward B. Headley, Cincinnati.

McGill—Kalman C. Kunin, Cleveland.

Marquette University—Betty L. Voelker, Cleveland.

Northwestern University—James L. Finley, Petersburg, and Richard J. Yoder, Akron.

Temple University—Thomas H. Eaton, Cleve-

land, and William T. Ellis, Canton.

University of Chicago—James M. Smith, Mason.

University of Colorado—William M. Stuckey, Mansfield.

University of Rochester—Robert P. Shanewise, Cuyahoga Falls.

University of Tennessee—Perry M. Berg, Cleveland, and Sol D. Braver, Cleveland Heights.

University of Toronto—Harold Broder, Cleveland; Sidney W. Helperin, Cleveland, and Isaac J. Mercovitch, Baltimore, Md.

University of Wisconsin—William S. Dietrichson, Mansfield.

Woman's Medical College—Mary E. Frank, Canton.

University of Rochester—Robert B. Rardin, Shaker Heights.

University of Vytautas, Lithuania—Alfonsas Kisielius, Elizabeth, N. J.

University of Cracow, Poland—Borys A. Filipczak, Toledo.

University of Vienna—Alexander Korosi, Willobee, Ohio.

University of Kaunas, Lithuania—Danielius Degesys, Cleveland.

University of Tubingen, Germany—Maria V. Ryan, Columbus.

University of Sao Paulo, Rio de Janeiro—Nicolau S. Assali, Cincinnati.

New Allocation of Federal Health Funds in Ohio Legally Approved

The Ohio Department of Health, under its announced new system of distributing Federal funds to local health departments, is within its legal right to abolish positions of employees formerly assigned to local districts, an opinion of the Attorney General confirms.

The new procedure as outlined by Dr. John D. Porterfield, director of health, was reported in the August issue of *The Journal.* The following explanation of the change in the department's policy and inquiry directed by Dr. Porterfield to the Attorney General give a gist of the new procedure.

"The Ohio Department of Health receives from various Federal agencies grant-in-aid funds for the purpose of providing assistance to local health departments in this state.

"During the present Federal fiscal year we will receive approximately $1,250,000 of which $250,000 will be used for the employment of personnel in the central office. Approximately $1,000,000 will be used for the employment of public health sanitarians, public health nurses, and clerks, who are assigned to local health departments.

"For obvious reasons the employment of personnel by this Department, for assignment to local health departments, is too costly and impractical. Therefore, beginning July 1, 1950, the Ohio Department of Health is planning to distribute Federal grant-in-aid funds to the local health departments that qualify to receive such funds on the basis of a formula, to be adopted by the Director of Health.

"In order for a local health department to become eligible to participate in Federal grant-in-aid funds, it will be necessary for the local board of health to employ, from local funds, a full-time health commissioner, public health nurse, public health sanitarian and clerk. It is conservatively estimated that approximately 70 of the 203 statutory health districts in this state will qualify under these standards and will, therefore, be eligible to receive Federal grant-in-aid funds.

"During the past year we have employed 330 public health sanitarians, public health nurses, clerks, part-time physicians and clinicians, pursuant to the provisions of the Ohio Civil Service Law, who have been assigned to local health departments. It is planned to abolish these positions as of June 30, 1950, with the hope that local boards of health will reemploy these people using Federal grant-in-aid funds provided through this Department. . . .

"Can the positions referred to . . . be abolished as a result of a change in departmental policy with respect to the allocation of Federal funds to local areas—such change being predicated on the fact that present procedures are too costly and unsatisfactory?"

Attorney General Herbert S. Duffy, in Opinion 1846, while agreeing that such employees come within the classified civil service of the State of Ohio, quoted from a court decision as follows: ". . . Provisions, however, do not restrict public authorities in their bona fide efforts to effect necessary and desirable economies, or to prevent the laying off of an unessential employee for reasons of economy."

After quoting excerpts from Federal and State laws and opinions, the Attorney General concluded: "In view of the foregoing, it is my opinion that the Department of Health may, in accordance with the plans presented by it and approved by the Surgeon General of the Public Health Service, abolish such positions as public health sanitarians, public health nurses, clerks, part-time physicians and clinicians."

Course in Diseases of Chest

A postgraduate Course in Diseases of the Chest, sponsored by the Council on Postgraduate Medical Education and the New York State Chapter of the American College of Chest Physicians, will be held at the New Yorker Hotel, New York, November 13-18. Further information may be obtained from Dr. Frank R. Ferlaino, secretary of the Council on Postgraduate Medical Education, 580 Park Ave., New York 21, N. Y.

Doctors and the War . . .

State Association Acts To Coordinate Military Requirements With Civilian Needs; Doctor-Draft Explained; Reserve Status Discussed

DEVELOPMENTS in the war and national military preparedness program which affect members of the medical profession have been rapid within the past few weeks. The situation is fluid with new developments coming almost daily.

Here are the high lights up to the time this issue of *The Journal* went to press, all of which will be covered in detail in this article:

1. The Council of the Ohio State Medical Association meeting on September 16 and 17 set up machinery to bring about a coordination between the requirements of the armed forces for medical officers and the needs of communities, including medical schools, hospitals, insitutions, and other agencies, for adequate medical and health services.

President E. O. Swartz, Cincinnati, was authorized by The Council to appoint a committee of 12 physicians to serve as a Military Advisory Committee.

Each County Medical Society will be asked by The Council to appoint a similar committee to advise the state committee on local matters.

Selection of a physician to serve as chairman of the Military Advisory Committee and on a full-time basis as administrator of the work of the committee was authorized.

2. The so-called doctor-draft law was enacted by the Congress and signed by President Truman, giving the latter authority to call into military service physicians under 50 years of age if they are needed by the armed services.

3. Immediately following passage of the doctor-draft law, the Department of Defense announced certain revisions in the procedures for calling up medical reserve officers, which may reduce the number of reserve officers to be called to active service at this time.

O. S. M. A. PROGRAM

President Swartz has announced that a physician from each of the State Association's 11 Councilor Districts will be named by him to the Military Advisory Committee. Announcement of the committee personnel will be made just as soon as letters of appointment can be sent out and acceptances received.

Dr. Robert Conard, Wilmington, has been appointed by Dr. Swartz as chairman of the Military Advisory Committee. Dr. Conard served in a similar capacity during World War II and was generally recognized as having done an outstanding job in efforts to bring about a coordination of military and civilian needs during the war years.

Dr. Conard also was named by The Council to serve on a full-time basis, with compensation, as administrator of the activities of the Military Advisory Committee. He will discontinue his private practice in Wilmington on October 1 in order to carry on this assignment. Office space for Dr. Conard, together with personnel and facilities, have been provided in the Columbus Office of the Ohio State Medical Association.

MILITARY ADVISORY COMMITTEE

The Military Advisory Committee will function as a part of the Association's Committee on Emergency Medical Service. The military phases of the work and responsibilities of the Committee on Emergency Medical Service will be handled by the Military Advisory Committee under the chairmanship of Dr. Conard.

Civilian defense activities and responsibilities will be carried on by a Committee on Civilian Defense under the chairmanship of Dr. C. C. Sherburne, Columbus. The personnel of the second committee will be the same as the Committee on Emergency Medical Service which has been in existence for the past year or so.

Dr. Conard and Dr. Sherburne will serve as co-chairmen of the over-all committee—Committee on Emergency Medical Service. This dual set-up will bring about close coordination and cooperation between the Military Advisory

Committee and the group directly concerned with civilian defense matters.

Members of the Military Advisory Committee of the State Association will have the responsibility of securing necessary professional and biographical data regarding physicans in their respective areas, making recommendations regarding civilian needs in the districts, and advising as to the availability or essentiality of physicians for military or civilian service.

Such information will be obtained through personal investigation and through consultation with the Military Advisory Committees of the various County Medical Societies. A request to each County Medical Society asking it to name such a committee will be sent out in the near future by President Swartz.

DOCTOR-DRAFT LAW

The Doctor-Draft Bill passed in August by Congress, was signed by the President on September 9. Details of administration are being worked out according to Selective Service and military regulations, and will be issued on the basis of authority granted by the law.

Following are interpretations of provisions of the law issued by the Washington Office of the A. M. A. shortly after the law was transmitted to the President.

Who Must Register? Physicians and dentists **who have not reached the age of 50** and are **not members of military reserves.** Veterinarians, optometrists, pharmacists, osteopaths and/or other specialist categories if specified by the President. (Law specifically states that it does not apply to military reserves; they are already subject to military orders.)

Who Are Eligible for Draft, and in What Order Will They Be Called? Any registrant (above) is subject to induction if acceptable to the military. The law provides that registrants will be called up on the following priority:

1. Former A. S. T. P. and V-12 men who have **not served on active duty** (military, coast Guard or Public Health Service) and others **deferred from service to continue their education** during World War II, and who have had less than 90 days of active duty (military, C. G., or PHS).

2. Members in the above groups who have had **more than 90 days active duty** (military, C. G., or PHS) but **less than 21 months.**

3. With no reference to above groups, those who did not have active service, (military, C. G., or PHS) subsequent to September 16, 1940; this could include postwar medical graduates as well as other physicians who have not served and have not reached their 51st birthday.

4. All others, including World War II non-reserve veterans. Men in this group to be called on basis of extent of duty; those with least duty first, etc.

When Will Draft Take Effect? Not until the President sets a time for registration. Nothing official, **but registration deadline probably in next few weeks.** Men will register at "appropriate points of registration" in community. After registration, Selective Service will place the man in one of four classes listed above. Then, if to be called, he will be ordered up for his physical. Following this, 21 days to set affairs in order before reporting to Armed Forces Induction Station. Subsequently he will be offered a commission and assignment to a service.

Can Registrant Get Reserve Commission? Yes, if acceptable to military. If the man applies for and is granted a reserve commission, he will come under military orders and Selective Service will not process him further.

Who Gets the $100 Pay Bonus? Every reserve officer called to duty, on voluntary or involuntary basis, receives the extra $100 per month. Men required to register under this act also may qualify for the $100—but only if they volunteer prior to their actual induction.

Who Is Eligible for Deferment? Actual deferment is at the discretion of local Selective Service boards. However, the law states that "the President is authorized to provide for" certain deferments. Action under this clause would be based on the registrant's previous military service, his dependency status and any undue hardship that might ensue.

Will Profession Advise Selective Service on Men to be Called? Yes. The law provides for establishment of a National Advisory Committee "which shall advise SS system and coordinate work of state and local volunteer advisory committees with respect to selection of needed . . ." professional personnel. Committee will be composed of men "outstanding in medical, dental and allied services."

Medical and Dental Professions Must be Represented on the National Committee, but representation of other professions not required. Law does not control local advisory committees; whether these are established and made effective depends on local conditions.

Will Draft Create Critical Doctor-Shortage Areas? Conceivably it might. But law itself attempts to set up safeguards. It says the National and state and local committees shall **"give appropriate consideration to" civilian as well as military medical and dental requirements.** Another section underscores this policy: "Maintenance of national health, safety or interest" should be considered in granting deferments. In calling up reserves, **Army commanders** also under orders to give careful consideration to doctor-shortage areas.

How Many Will Be Drafted? Military medical

officers hope enough men now will volunteer to meet requirements. They are prepared to use law's authority for mandatory inductions, but are confident that these cases will be rare. They are hopeful that the $100 bonus, which is denied to men involuntarily inducted under this act, will attract registrants to volunteer.

Other Provisions: One section of law authorizes transfer of medical officers from one service to another, with consent of the officer and of services involved. Officer protected in promotion, retirement and pay . . . Another provided that any persons who have served in armed forces or PHS after September 16, 1940, and is recalled, may be "promoted to a grade commensurate with his education, experience and ability." . . . Law states "it is the sense of Congress" that Selective Service deferments will be granted to premedical, predental and allied students in numbers equal to the present such enrollment.

This ruling more or less formalizes present Selective Service policy and sets a total figure for deferments in each professional category . . . Inductees under doctor-draft required to serve **21 months** . . . Anticipation is that Advisory Committees will operate like Procurement and Assignment of World War II . . . Bonus of $100 now goes to all reserves, whether called up voluntarily or involuntarily; on this Congress reversed comptroller general, who had ruled that reserves called up involuntarily not eligible . . . Doctor-draft law, an amendment to Selective Service Act, **expires with that law next July,** unless extended by Congress. **(Entire law has been covered by above outline.)**

Vinson Says 5,000 More Military Doctors Needed by Next July 1. In House debate on the doctor-draft bill, Chairman Vinson of the Armed Services Committee cited these figures on military medical lineup:

Overall: 6,226 doctors now on active duty; total of 11,250 needed by next July 1, on basis of present military manpower planning for 2,500,000 men.

Army: 20,000 participated in A. S. T. P. program, of whom 12,500 served on active duty and 1,000 were discharged for physical or other reasons. Of remaining 6,500, about 2,000 failed to graduate for various reasons, and 1,500 of those in practice would be ruled out for physical and other reasons. This leaves approximately 3,000 men, educated in whole or in part by Army, who have not served and would be first to be called up.

Navy: 11,176 trained in whole or part in V-12 program; 5,872 of these have served at least two years on active duty. This leaves 5,304 with no service, but 1,429 of these are in Reserve and subject to call. Of remaining 3,875 enrolled in program, 1,262 did not finish school. This leaves at the most 2,613 who have finished school and would be eligible.

On paper, these sources alone—A. S. T. P. and V-12—could supply all military medical requirements for the next year. Requirements, 5,024; A. S. T. P. and V-12, 5,613. However, military planners have warned that physical handicaps, practice in doctor-shortage areas and other factors will reduce this potential supply well below the requirements.

Military's Past Handling of Medical Manpower Comes in for Sharp Criticism. Preceding vote on the doctor-draft bill, several members of the House took the opportunity to register sharp criticism of the way physicians had been used by the Armed Forces in World War II.

To these criticisms, **Mr. Vinson** repeatedly replied that he had assurance from the three Surgeons General that **physicians would not be wasted this time.**

RESERVE OFFICER PRIORITIES

Shortly after passage of the doctor-draft act —in fact, on September 7—Secretary of Defense Johnson (who subsequently resigned) issued an order to the Army, Navy and Air Force establishing new priorities in calling medical and dental reserve officers to active duty.

These orders were in effect as this issue went to press. It is problematical at this time whether these orders will be permitted to stand or will be rescinded by General Marshall, who has been named as Johnson's successor.

Following is the full text of Johnson's memorandum to the armed services on priorities in calling up reserve officers:

Memorandum for the Secretary of the Army
Secretary of the Navy
Secretary of the Air Force

Subject:

Priorities to be observed in calling medical and dental reserve officers to active duty.

By direction of the President, the military departments will strictly observe the following order of priorities in calling to active duty medical and dental reserve officers who are not members of organized reserve units:

First Priority:

Medical and dental reserve officers who were V-12 or A.S.T.P. participants, and who have had no prior military service as commissioned medical or dental officers. It is desired that substantially all this group of officers be called before calls are made to the individuals in the second priority.

Second Priority:

Medical and dental reserve officers who were V-12 or A.S.T.P. participants, and who have had prior military service. These individuals will be classified by numbers of months of previous active duty, and will be called in inverse order of the number of months of previous active duty they have to their credit. It is desired that substantially all of this group of officers be

called before calls are made to the individuals in the third priority.

Third Priority:

Other reserve officers.

Exceptions:

Exceptions may be made to the above priorities in the case of medical reserve officers who have not yet completed twelve full months of medical internship. These individuals, if actively pursuing a medical internship, will be granted a delay in call-up until they have completed a total of twelve full months.

Additionally in special cases, where a military department can show a military need for the services of a particular individual or group of individuals with special qualifications whose prior service might otherwise tend to warrant their delay in call-up under the policy enunciated above, exceptions may be made so as to authorize their recall to duty, but then only after obtaining the approval of the Director of Medical Services.

Attention is invited to the memorandum of July 20, 1950, addressed to the Secretaries of the military departments by which the military services were authorized to make calls into the Federal service of certain organized units and of individual members of the Reserve. The second paragraph of that memorandum indicated that advance notice to me of the proposed issuance of orders of categories of specialists in the Reserve was required. In keeping with that directive, I desire specific notification of all plans with reference to future calls to be made for all medical and dental officers, and I wish to receive them sufficiently in advance of the proposed publication of orders so that they can be reviewed in my office.

In addition, to the extent that medical and dental reserve officers who are not members of organized reserve units have heretofore been ordered to duty but have not yet reported for duty, in a priority order other than the one set out above, I want the Secretary of each of the military departments to review its procedures in issuing such calls, in order to eliminate inequities to the maximum possible extent.

The Director of Medical Services will request information from the military departments which will permit me to be kept fully informed monthly of the status of all medical and dental personnel called to active duty.

DRAFT NOT OPERABLE YET

Until the new regulations were put into effect the Department of Defense had exercised no right to review calls for medical reserve officers. The three services had made their own decisions on the number of officers to be called, the time of call and the categories of specialists affected. These must all clear through the Department of Defense now before taking effect.

It must be kept in mind that the Selective Service act permitting the drafting of physicians has not become operable and cannot until a registration date has been announced and induction machinery put into operation.

For that reason the armed services may have to call certain medical reserve officers to active duty to meet existing needs. However, all are hoping to keep such calls at a minimum, anticipating a large number of volunteers from among physicians eligible to the draft. The services point out, nevertheless, that some reserve officers may have to be called to fill important specialty posts which cannot be filled by volunteers because of their lack of qualifications and experience.

SITUATION IN OHIO

The Army is at present calling to active duty a certain number of Ohio medical reserve officers in certain specialty categories. Advice of officers of the Ohio State Medical Association in the selection of these officers with respect to their availability was solicited and given. An effort was made to clear as available only medical reserve officers whose services were not absolutely necessary in civilian practice and only those with the least amount of World War II service. Priorities taking into consideration the time spent on active service in World War II were set up and followed.

Since the Ohio quota of 38 medical reserve officers for the present call was established, new instructions have been issued to Army commanders which should reduce the number of World War II officers to be called from 50 to 75 per cent. How this will affect Ohio is not known definitely but in all probability Ohio will not have to furnish as many World War II medical reserve officers as anticipated and orders issued to some already to report for active duty may be rescinded.

STATEMENT OF SURGEON GENERAL

Following is an explanation issued by the Surgeon General of the Army on September 12. According to the statement the new move, taken in view of legislation providing for selective induction of physicians, dentists and members of other allied professions, will have the effect of limiting the recall of officers with World War II service to a maximum of 364 physicians, 126 dentists and 29 veterinarians. The actual number recalled will be considerably less than this figure, it was estimated.

The new special quotas restricting World War II recalls will have no effect on total Army Medical Service recall requirements, according to Major General R. W. Bliss, Army Surgeon General. The new policy will, however, have the effect of strengthening the preferred status of professional officers with World War II service, thereby reflecting the active duty priorities contained in the new legislation.

Since it is estimated that 90 to 120 days will be required after the passage of the legislation before physicians, dentists and others actually enter military service, the policy is an interim measure, designed both to protect those with the most military service and assure an adequate

number of professional officers for the Army before the new legislation becomes effective.

HOW IT WILL WORK

This is the way it is expected to work:

Each Army commander will still have the same over-all quota of Army Medical Service personnel as originally announced. However, his quota will now consist of two parts—the new special quota and the balance of his over-all allocation. In filling the special quota, every effort will be made to fill it insofar as grade, specialty and numbers permit, with volunteers, including former A.S.T.P. students with no active service, and reserve officers with no World War II service. If necessary, officers with World War II service may be recalled when others are not available in the required grades and specialties. The balance of the over-all quota must be filled with volunteers and reserve officers without wartime service and will not be filled with World War II officers.

All officers with World War II service not included in recalls for the special quota in each Army area will be temporarily deferred from recall, except those assigned to duty with alerted National Guard or Organized Reserve units. The policy will not apply to officers assigned to these units.

NAVY STARTS CALLING V-12'S

As soon as Congress had passed the doctor-draft law, the Navy started calling up its 1,200 reserves who participated in the V-12 program. By the time this group is in uniform, the Navy expects that another 2,500 or so former V-12's who were not in the reserves will be made available, either as volunteers or under the mandatory provisions of the new law. This means that for the next few months Navy will be able to greatly reduce, but not entirely eliminate, its calls on World War II medical veterans, according to Washington observers.

Appointment and concurrent assignment to active duty as Reserve Officers of women physicians, dentists, and allied specialists, has been authorized, it was announced by the Department of the Army.

Appointments will be in grades from first lieutenant to colonel, depending upon age, experience, and professional qualifications. The pay, allowances, dependency and retirement benefits which accrue to male officers will apply to the women medical reservists.

Women physicians and dentists will also draw the $100 a month professional pay allowed above the base pay of their commissioned rank. They will be eligible for service in every type of military medical facility, with the exception of forward medical installations in combat zones.

A similar policy has been announced in regard to women physicians who wish to receive reserve commissions in the Air Force.

AIR FORCE

Physicians who received all or part of their training under the A. S. T. P. or the Navy V-12 programs and who do not have commissions with other military services are eligible to receive commissions in the U. S. Air Force Medical Service, Major General Harry G. Armstrong, Surgeon General of the Air Force, announced.

POLICY ON RESERVE UNITS

A policy under which profesisonal medical service officers assigned to Reserve or National Guard units called to active duty will be recalled only to the extent they can actually be utilized, has been announced by the Department of the Army.

Two general types of units will be affected by this policy. **The first** includes Army divisions, headquarters of medical battalions and groups, medical clearing companies, medical field laboratories, field hospitals, mobile army surgical hospitals, and all non-medical units with medical personnel included in their organizations.

Units included in the **second group** are evacuation hospitals, convalescent centers, general and station hospitals, general laboratories, hospital trains, and general dispensaries.

For the **first group**, the policy will be to call all medical service officers, including physicians, dentists and nurses, to duty with their units. However, **only the minimum required for actual training** will remain with their units during the training period. For example, although an infantry division is authorized 42 physicians, only 17 will be retained by the division during its training period. **The balance will be assigned to the hospital serving the division.** Provision has been made for rotation to assure that each physician has the greatest possible opportunity to continue a balanced medical practice, both with the unit in the field and at the station hospital. All the division dental officers would be utilized at the camp hospital or dental clinic.

For units falling in the **second group**, only the professional **personnel actually required for training or support** will be recalled. The balance of the assigned medical service officers will **remain at home until a short time before the unit is actually ready for operation.** Thus, in the case of a 1,000-bed general hospital, only three physicians and two nurses will initially be called to duty with the unit. The balance of physicians and nurses will await a warning order for the unit's deployment. Dental officers will be used in the same manner as those assigned to units falling in the first group.

All Medical Service Corps officers and enlisted personnel assigned to all types of units will be called to active duty with their units.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

SOCIALIZED MEDICINE THE REAL ISSUE ON NOV. 7

As fodder for the 1950 General Election campaigns, the Democratic National Committee, over the signature of William M. Boyle, Jr., its chairman, has issued a bulletin plugging the Truman scheme of national compulsory health insurance. If anyone wanted tangible evidence that the issue of socialized medicine is definitely a political issue this Fall, there it is.

Mr. Boyle's comments are, as usual, disarming; full of half-truths and mis-statements.

In the first place, he contends that the Truman program is not "socialized medicine." Since when isn't a medical program controlled by government and financed from tax funds, socialized medicine?

The bulletin, using material from the Committee for the Nation's Health for reference, protests that voluntary medical and hospital plans are woefully inadequate, contrasting them to what he calls "national health insurance." Naturally, no voluntary, private enterprise project is recognized as adequate to those who favor a socialistic state. In the second place, the Truman scheme would not be insurance, as there would be no gearing of benefits to income—it would be nothing but a medical dole, paid for by compulsory taxation of one kind or another.

Mr. Boyle alleges that the cost of the Truman scheme would be $48 per year per average family. That statement is entirely fallacious. He and everyone else knows that the cost per family would be considerably higher, simply because everyone would be assessed taxes indirectly to meet the difference between the Social Security payroll tax and cost of the Truman scheme.

Mr. Boyle sneers at the "lavish advertising fund of the A. M. A." but says nothing about the millions of dollars which have been spent by Social Security Administrator Ewing to promote compulsory health insurance and about the horde of press agents on the payroll of that bureau, most of whom are engaged in publicizing this and other pet socialistic projects of the bureau.

Physicians, and others, who want no part of compulsory health insurance, in other words, socialized medicine, should realize that when they go to the polls on November 7 to cast their votes for a candidate to the next U. S. Congress, they will be voting indirectly on the issue of socialized medicine. There can be no doubt of that—Mr. Boyle has left no alternative. They should know how the candidates stand on this question—then vote accordingly.

TWO-YEAR RULE ON FILING W. C. FEE BILLS AND REPORTS

There seems to be some confusion and misunderstanding on the part of some physicians regarding the so-called two-year rule of the Ohio Industrial Commission applying to the filing of fee bills and reports of injuries. Failure of some physicians to conform to the rule has barred them from receiving compensation for services rendered to claimants.

Rule No. 6 of the Commission adopted on August 9, 1940, and still in effect, reads as follows:

"Time Limitation on Filing Bills and Reports of Injuries. Fee bills for medical, hospital and nursing services and for medicines and appliances, are forever barred from payment unless they are filed within two years from the time such services were supplied, or within six months from the time the Commission has assumed jurisdiction in a contested or re-opened case. Claims for injuries must be filed within two years from the date of injury."

This rule appears in the Fee Schedule Booklet issued by the Commission. It has been publicized repeatedly by *The Journal.* Nevertheless, some physicians apparently are unaware of it.

The two-year rule starts on the day services were rendered—not from the date of the last treatment, as some physicians believe. The rule will not be waived by the Commission unless extraordinary circumstances exist.

Therefore, it behooves each physician to file his fee bills and reports on Workmen's Compensation cases very promptly. In fact, other rules of the Commission make it mandatory for a physician to file such blanks at intervals of 60 days at the most.

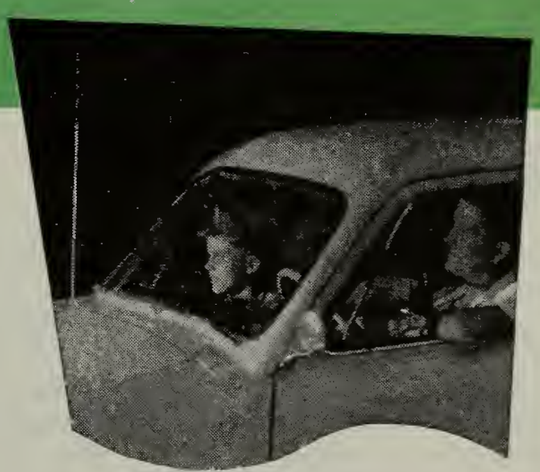
Unless the Commission receives these bills and reports at frequent intervals, it cannot keep up with the progress of cases, an important point in the huge administrative machinery of the Commission.

HOW TO SET UP AN OFFICE AND WHERE

Writing in *Future,* a bulletin issued by the California Medical Association for medical students, interns and residents, Dr. Frank F. Schade offers young physicians some excellent advice on how to set up an office and where. Excerpts from his timely article follow:

"Have no illusions. It will be difficult for the first few years, if you set up on your own. If that is your plan, decide where you want to





"A high percentage of cases of seasickness and carsickness can be aborted or prevented by suitable doses of dimenhydrinate (Dramamine)."

—Council on Pharmacy and Chemistry, New and Nonofficial Remedies, J.A.M.A. 143:815 (July 1) 1950.

DRAMAMINE® Brand of Dimenhydrinate—for the prevention or treatment of motion sickness—is supplied in 50 mg. tablets and in liquid form.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

live, and go there to practice. Wherever you go, it will be difficult, so go to the place where you want to spend the rest of your life, to rear your family, to be a member of the community.

"Care should be taken in selecting your office site and in purchasing equipment. Consider the funds you have available, or that you can borrow, and then keep within your budget. Large, pretentious offices are not necessary at the start. The larger the offices, the more equipment and furniture will be necessary; you won't need a lot to begin with, and you must keep your initial expenditures down.

"Choose the location for your office carefully. Avoid old, run-down and deteriorating areas. What will the area be like in ten or more years? The fewer times you move your office, the better, so choose with an eye to the future.

"Once the location is chosen, the lease is very important. Read it carefully. If you have an attorney, consult him about it.

"Furnishings and equipment should be kept to the minimum compatible with good taste, comfort and efficient care of your patients. For the waiting room comfortable, serviceable furniture should be stressed, keeping in mind such factors as wearing quality of upholstery, ability to be cleaned readily and resistance to staining. Large, multiple seating units, such as davenports, should be avoided. Good lighting is essential. Above all, keep the reading material for your waiting patients up to date . . . as magazines become outdated, dispose of them, and don't depend upon the old, cast-off magazines from home for your waiting room.

"The amount of professional equipment necessary will vary somewhat with the type of practice and the location, the maximum being needed for suburban or rural general practice. The usual mistake is to purchase too much and too great a variety of instruments and other equipment. You can always add as you go along, as your practice increases and as the necessities arise. Deal with good, reputable firms, and keep in mind that the actual price paid does not always determine value. There can be no substitute for quality."

DOCTORS NEED THIS KIND OF PUBLICITY

"Lima Beane" who pens a column for the *Lima News* recently addressed the following open letter to the physicians of Allen County:

"Dear Doctors: Your generous donation of time and effort in conducting Lima's pre-school clinics proves that you have the welfare of the entire community in mind. The clinics themselves are a wonderful thing. They tend to raise the general health level throughout the city. The doctors who handled the clinics are to be congratulated."

That's the kind of publicity the medical profession should have in these days when too many folks don't know about the good things which many physicians are doing for their community. Also, let this be a lesson to those physicians who are failing in their community obligations and responsibilities. We join "Lima Beane" in congratulating the physicians of Allen County on a job well done.

ALLEGES "OHIO DOCTORS BACKING TAFT"

"Ohio Doctors Backing Taft," reads a headline on an article published in the July 28 edition of the *Akron Labor News.*

According to that paper: "Ohio's medical associations have thrown their weight and fund-raising machinery behind Senator Taft's campaign for re-election."

Perhaps the *Akron Labor News* meant to say that individual physicians are working for Taft. In fact, it states: "One group, the Ohio Physicians Committee for Taft is engaged in setting up a political committee of medical men in each of Ohio's 88 counties."

Another paragraph of the article is intriguing, especially the source of the information. Quote: "According to the Committee for the Nation's Health, which exposed the doctors' dabbling in politics, these groups are to campaign for Taft with 'special literature, radio and newspaper messages, group meetings and intensive work by representatives in the field'."

Now that the doctors of Ohio have been properly "exposed" they can "dabble" to their heart's desire. If they want to "dabble" for Taft, the *Akron Labor News* tells them how to do it.

P. S. Chicago, Aug. 9—(AP)—William Green, president of the American Federation of Labor, said today the AFL and the CIO is united "to bring about the defeat of Sen. Taft of Ohio."

Green and the AFL executive council met today with Joseph D. Keenan, director of the AFL labor league for political education, to discuss the fall election campaigns.

"We are confident we will defeat Sen. Taft as we did Sen. Brooks of Illinois, Sen. Ball of Minnesota, and Sen. Revercomb of West Virginia," Green told a news conference.

Keenan said the AFL and CIO jointly will raise about $100,000 to fight against Taft's re-election in Ohio.

"We have decided to concentrate on a program to get out the vote of labor and its friends between Aug. 15 and Oct. 1," he said.

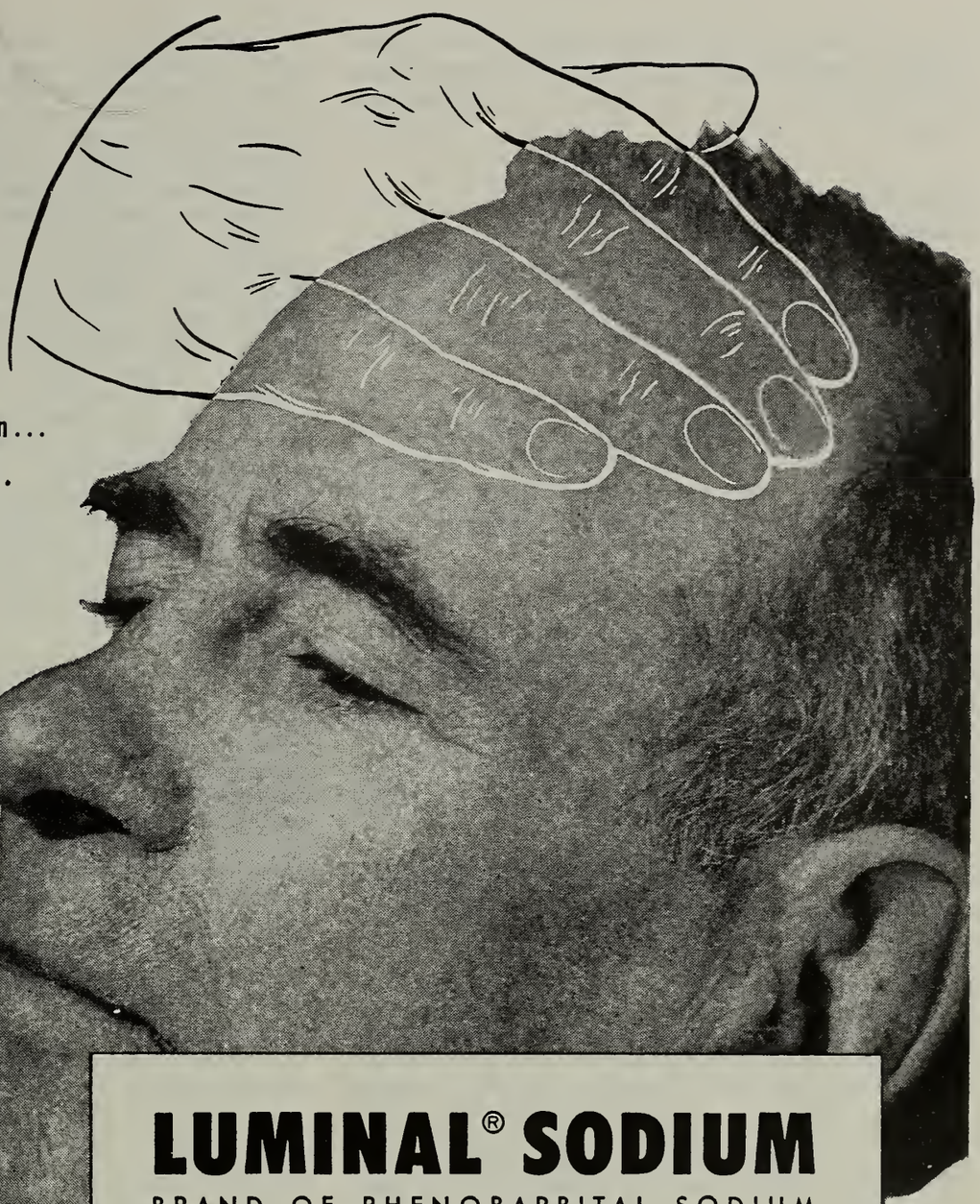
CHANCE FOR DOCTORS IN RURAL AREAS TO ACT

The Ohio Farm Bureau News in an appeal to its members to vote at the November 7 election, points out that in the May, 1950, primary elections, only 17.8 per cent of rural Ohio's potential voters went to the polls.

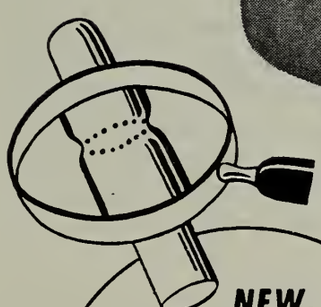
Those who are interested in good government should do some missionary work among the rural folk. They are as a rule sound, conservative people—the kind of people who support sound, well-qualified candidates when they vote.

Here is a chance for physicians in rural and semi-rural areas to get in some good licks.

the quieting hand



— in preoperative apprehension...
postoperative restlessness...
insomnia...
epilepsy...
dysmenorrhea...
vomiting of pregnancy...
eclampsia...
hypertension...
pyloric spasm...
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Sedative... Hypnotic... Antispasmodic

In conditions of excitement of the nervous system, as well as in certain spasmodic affections, Luminal Sodium acts as a soothing, quieting agent to tranquilize hyperexcitability or to curb convulsive paroxysms. Small doses have a pronounced sedative and antispasmodic action. Large doses are markedly hypnotic.

For oral use... tablets of 16 mg. (¼ grain), 32 mg. (½ grain) and 0.1 Gm. (1½ grains).

For parenteral use... solution in propylene glycol 0.32 Gm. (5 grains) in 2 cc. ampuls;

powder 0.13 and 0.32 Gm. (2 and 5 grains) in ampuls.

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They should talk to their patients about this, urging them to get out of a rut and exercise their right to have a voice in governmental affairs.

THE PROBLEM OF RISING HOSPITAL COSTS

The problem of rising hospital costs—the biggest portion of each dollar spent for medical care—has hospitals worried, physicians worried and patients worried.

The reasons for this are enumerated in the following article published in a recent issue of the *Columbus Academy of Medicine Bulletin*, which article, also, reveals that there does not appear to be much hope for a change in the situation in the near future:

* * *

"Why does a hospital room cost so much more than a hotel room?"

Every physician must have heard that plaintive query from hundreds of patients. The hospital people hear it, too—frequently.

Last month a group of hospital superintendents, admitting officers and medical social workers made an effort to explain the hospital's side of the story.

The program was called "Hospitals Talk It Over" and it was part of a series of "Institutes on the Community and Its Resources." The meeting was held at Mees Hall, Capital University, and was attended by about 100 persons, mostly social workers.

Mr. Erwin C. Pohlman, superintendent of Grant Hospital, gave a careful breakdown on the "average cost of a hospital visit for the average hospitalized patient." The figures are based on 1949 operations at Grant Hospital, but other hospital officials agreed that the figures would come close to the average at all hospitals.

In answer to the opening question, "Why does a hospital room cost so much more than a hotel room?" Mr. Pohlman pointed out that 71 per cent of the hospital's charges to the average patient are for services that would not be provided in a hotel.

The average amount collected per patient was $118.16.

Of this amount $40.91 was spent by the hospital for nursing service and education, $24.44 for food, $7.02 for medical and surgical costs, $6.20 for pharmacy supplies, and $5.84 for laboratory.

The remaining amount was spent on plant operation and maintenance, administration, housekeeping and textiles, and laundry.

Another breakdown showed that 64 per cent of the amount collected per patient was used for salaries and 36 per cent for other services.

Another question frequently asked about hospitals is this: "Since hospitals charge for their services, why do they have to receive gifts and put on special drives?"

Mr. Pohlman gave a plain answer to that.

The hospital received an average of $118.16 in payment for each patient last year. The average cost per patient was $117.17.

That leaves a net cash surplus per patient of 99 cents.

The average hospital has from 5,000 to 10,000 patients a year. This would mean an annual net surplus of $5,000 to $10,000 to cover costs of replacement of used equipment, modernization, depreciation, expansion.

It is obvious that the available surplus will not cover these necessities.

Mr. Robert M. Porter, superintendent of Children's Hospital, said his hospital had found it necessary to purchase $45,000 worth of equipment alone in 1949.

Unless there is a decided change in general economic conditions in the country, it is not likely that hospital costs will go down in the near future. It is more likely that they will go up. One reason that the costs may increase is the average rate of pay of hospital employees—$5.00 a day—which may have to be raised. It may become necessary to put hospital employees on a five-day week. This also would increase costs. And if a retirement plan should become necessary for hospital employees, costs would go up again.

The average total cost of hospitalization per patient per day was $14.57 in 1949. Compared to the average total cost of $6.39 per patient per day in 1940, this is a 128 per cent increase in nine years.

But improved medical and surgical care, better drugs and improved skills have reduced the length of stay of the average hospital patient from 11 days in 1940 to 8.1 days in 1949. The average total cost of hospitalization per patient, therefore, has increased only 68 per cent. This is comparable to other increases in the cost of living.

Although average per diem costs may continue to rise, average cost per patient for his entire hospital stay may hold fairly level in the future, it was pointed out, because continued improvement in medical care may be expected to reduce the average hospital stay even further.

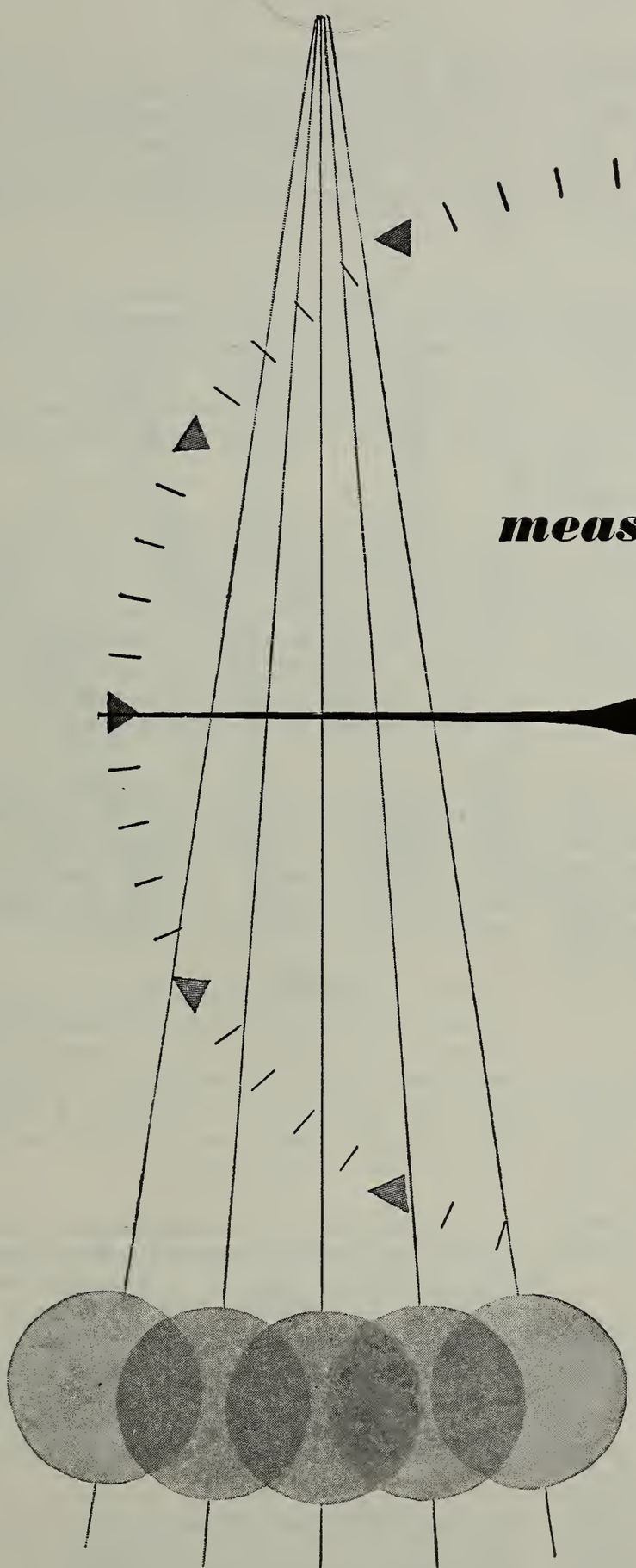
In our opinion, data such as the above should be brought to the attention of the public in every possible way. Unfortunately, many persons do not understand the financial problems of hospitals. Unfortunately, too many persons do not distinguish between the costs of hospitalization and the costs of professional services. If they believe the costs of illness are too high, they are inclined to place all the responsibility on the shoulders of the medical profession, failing to realize that there are others who take a share of the medical care dollar; failing to understand why some of these costs are at their present high level.

'TWOULD BE FUNNY IF IT WEREN'T SO SERIOUS

Columnist Dorothy Thompson ended one of her recent syndicated newspaper articles on the Korean situation with the following quip:

"Our leaders perennially refuse to analyze the minds of this country's enemies. They cannot remember 21 years back, nor do they read even what is all written down.

"Alternately they coaxingly patronize the greatest emperor of all the Russians, as 'Uncle Joe,' or repulsed, pettishly cry, 'barbarian bandit!' And then when the inevitable happens, they are caught holding, not a gun, but a public health program."



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Rapid anticoagulant effects are available with Heparin Sodium preparations, developed by Upjohn research workers. In a matter of minutes, coagulation time can be lengthened to offset danger from thrombosis and embolism. With Depo*-Heparin Sodium, prolonged effects lasting 20 to 24 hours may be obtained with a single injection. Therapy with these Upjohn anticoagulants is distinguished by promptness of action, simplicity of supervision, and ready controllability.

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Do You Know? . . .

Dr. W. Wendell Green, Toledo, was elected secretary of the American Proctologic Society at its annual meeting in Los Angeles, July 2-5. Other officers are: Dr. Hout R. Allen, Little Rock, Ark., president; Dr. Robert A. Scarborough, San Francisco, president-elect; and Dr. Rufus C. Alley, Lexington, Ky., treasurer.

* * *

Dr. K. W. Ascher, assistant professor of ophthalmology at the University of Cincinnati, gave a lecture on "Contact Lens and Aqueous Veins" at the 16th International Congress of Ophthalmology held in London, England, July 17-22. He also presented an extensive exhibit showing the development of present knowledge about aqueous veins since their detection in 1941.

* * *

Public Health Service grants totaling $230,773 are for research in four non-federal institutions on atherosclerosis. One of the grants in amount of $57,903 was made to the Cleveland Clinic. It will be used for research in the field of lipoproteins and arterial disease under direction of Dr. Irvine H. Page.

* * *

Dr. E. Herndon Hudson, director of the Ohio University Health Service, Athens, since 1940, has been named director and chief medical advisor of United Nations World Health Organization in Iraq. He will have the status of an international civil servant. Dr. Hudson has been given a year's leave of absence from his Athens post.

* * *

Major General Lewis Hershey, Selective Service Director, testified at a committee hearing in Washington that close to 60 per cent of draftees are unacceptable, but that not more than 50 per cent of these are for physical reasons. "I think we are rejecting more men now on the mental tests than we did in World War II," he said.

* * *

Dr. Charles C. Higgins, Cleveland, was elected vice-president of American Association of Genito-Urinary Surgeons at its annual meeting.

* * *

The fifth annual postgraduate course in diseases of the chest, sponsored by the American College of Chest Physicians, will be held October 16-20 at the St. Clair Hotel in Chicago. Details of the meeting may be obtained by writing the American College of Chest Physicians, 500 N. Dearborn Street, Chicago 10, Illinois. Veterans wishing to apply under the GI Bill may also receive information at this address.

Classes began September 11 for the second group of 12 medical record library technicians to receive 50 weeks of specialized training at the U. S. Marine Hospital, Baltimore, Md. Graduates are given the opportunity of joining the public health service, although there is no obligation.

* * *

Alpha Epsilon Delta, national premedical honorary fraternity has announced a national conference on premedical education to be held at Lake Placid, October 21-22, at the Lake Placid Club. Those wishing to attend may write Alpha Epsilon Delta, 303 Upland Road, Havertown, Pa.

* * *

The seventh annual meeting of the American College of Chest Physicians will be held November 12 and 13 in St. Louis, Mo. The group is meeting at the Hotel Statler jointly with the Southern Medical Association. The program committee for the meeting is composed of Hollis E. Johnson, M. D., Nashville, Tenn., chairman, and Otto C. Bantigan, M. D., Baltimore, Md.

* * *

Physicians who wish to place scientific exhibits at the Clinical Session of the A. M. A. in Cleveland, December 5 - 8, should apply at once. Application blanks may be obtained from the Director, Scientific Exhibit, American Medical Association, 535 N. Dearborn St., Chicago 10.

* * *

In an average year accidents result in the death of more than 5,000 preschool children between the ages of 1 and 4. This is greater than the annual number of deaths from diphtheria in this age group nearly a quarter of a century ago, when this disease was considered an outstanding cause of child deaths.

* * *

Improved methods for separating and preserving blood components of interest in atomic energy research will be sought in a program administered by the American Red Cross under a contract with the Atomic Energy Commission. Among technical personnel who will be engaged in the research are Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, and Dr. Warren E. Wheeler, also of the College.

* * *

At the third annual meeting of the Neurosurgical Society of America, September 14 - 16 at the Cloisters, Sea Island, Ga., the following were among those on the program: Dr. William A. Nosik, Dr. George S. Phalen and Dr. Julius Wolkin, all of Cleveland, and Dr. Rex H. Wilson, Akron.

AUREOMYCIN CRYSTALLINE
in Tularemia

Tularemia, which is a serious problem in many parts of this country, can be successfully treated with aureomycin.

All types of tularemic infection, with or without complications, respond promptly to the administration of this antibiotic.



AUREOMYCIN has also been found effective for the control of the following infections: acute amebiasis, bacterial and virus-like infections of the eye, bacteroides septicemia, boutonneuse fever, acute brucellosis, common infections of the uterus and adnexa, resistant gonorrhea, Gram-positive infections (including those caused by streptococci, staphylococci, and pneumococci), Gram-negative infections (including those caused by the coli-aerogenes group), granuloma inguinale, *H. influenzae* infections, lymphogranuloma venereum, primary atypical pneumonia, psittacosis (parrot fever), Q fever, rickettsialpox, Rocky Mountain spotted fever, subacute bacterial endocarditis resistant to penicillin, surgical infections, tick-bite fever (African), and typhus.

Capsules: Bottles of 25, 50 mg. each capsule. Bottles of 16, 250 mg. each capsule.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

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Buckeye News Notes . . .

Akron—Dr. Carl E. Krill participated in the International Pediatric Association meeting in Zurich, Switzerland, this summer.

Bryan—Dr. Alfred G. Goll was the subject of a feature article in the *Bryan Times* upon completion of 50 years of practice in July.

Chardon—Dr. Lucy Stone Hertzog spoke before the Childs Taylor Chapter of the D. A. R., where she outlined the origin of socialized medicine and its continuing threat in this country.

Cleveland—Dr. I. M. Hinnant recently addressed the Churchmen's League on the subject, "The Doctor Looks at Socialized Medicine."

East Cleveland—Dr. Jess J. Woodworth has been appointed head of the Department of Obstetrics and Gynecology at the Huron Road Hospital. He has been on the staff of the hospital since 1942.

Orrville—Dr. Robert P. Ulrich, Toledo, described the use of radium in treating diseases to members of the Rotary Club.

Painesville—Dr. Ewing H. Crawfis, superintendent of the Cleveland Receiving and Cleveland State Hospitals, spoke before the Kiwanis Club on the subject of mental illness.

Piqua—Dr. George A. Woodhouse, Pleasant Hill, spoke before the Women's Auxiliary of Piqua Memorial Hospital on "Socialized Medicine."

Quaker City—Dr. M. S. Lawrence addressed the Rotary Club on the subject of the county health board set-up, its history in Guernsey County and its functions.

Toledo—Dr. Maryloo Spooner, who recently completed her internship at Harper Hospital, Detroit, has been appointed on the staff of the Toledo Hospital Institute of Medical Research to conduct studies in the fields of cancer. She is the daughter of Dr. John P. Spooner, of Toledo.

Youngstown—Two physicians addressed civic clubs on the subject of "Defeat Plan No. 27" in July. Dr. C. A. Gustafson presented the discussion to the Rotary Club and Dr. W. C. Autenreith spoke before the Lions Club.

Youngstown—Four additional physicians recently announced opening of practices. They are: Dr. William E. Sovik, Dr. Aam A. Lerro, Dr. Edward H. Jones, Jr., and Dr. D. E. Beynon.

Youngstown—Dr. John LoCricchio, recently director of pathology and laboratory medicine at St. Vincent's Hospital, Bridgeport, Conn., has been appointed director of the Department of Pathology at St. Elizabeth's Hospital. He succeeds the late Dr. William Dean Collier, departmental head since 1936.

A. M. A. Clinical Session To Be Held in Cleveland, Dec. 5-8

The Fourth Clinical Session of the American Medical Association, designed primarily for the general practitioner, will be held in Cleveland, December 5-8.

The scientific sessions and the scientific and technical exhibits will be presented in the Cleveland Municipal Auditorium. Meetings of the House of Delegates will be held in the Statler Hotel. These sessions of the body elected to govern the affairs of the A. M. A. are attracting more and more non-delegate physicians each year.

Outstanding clinical teachers with recognized ability as speakers will headline the scientific demonstrations. Actual cases will be presented and discussed. Diagnoses, treatment and preventive measures as they fit into daily practice will receive the greatest attention.

Each clinical session will be limited to an attendance of 100 physicians. These small groups will make it possible for the general practitioner to enter actively into the discussion and to inquire about his own cases. Leading men in each of the fields under discussion will be available to help with the problems presented.

The steadily climbing registration of general practitioners at the clinical sessions and the comments of those participating indicate these meetings are valuable means of keeping abreast of developments in medicine. It is hoped that a record number of physicians will take advantage of the opportunity in December to attend. The program has been designed with that in mind.

Complete details of the meeting will be published in *The Journal of the A. M. A.* several weeks before the session.

Information regarding hotel accommodations and blanks for making hotel reservations are being published in current issues of *The Journal of the A. M. A.*

Radiological Society of N. A.

The 36th Annual Meeting of the Radiological Society of North America will be held in Chicago, December 10-15, with headquarters at the Palmer House. Scientific Exhibits will be displayed in the Palmer House. More than 60 papers as well as refresher courses are on the program. All members of the medical profession are invited.

Postgraduate Course in Allergy

The American Academy of Allergy in cooperation with the Faculty of Medicine of McGill University, is sponsoring a Postgraduate Course in Allergy October 26-28. There will be a fee of $40. Applications and requests for additional information should be addressed to Dr. Bram Rose, McGill University Clinic, Royal Victoria Hospital, Montreal, Canada.

A urinary tract infection

Resistant to "... *all available antibiotics and chemotherapeutic agents.*"[1]

TREATED WITH TERRAMYCIN

M.F., male, age 48

History: Pyelonephritis, 1½ years' duration following ureterocutaneous implants (mixed infection: P. vulgaris, E. coli, Staph. albus, enterococci); previous therapy with all available antibiotics and chemotherapeutic agents without response.

Therapy: Terramycin, 2 Gm. daily for 5 days; orally in divided doses q. 6 h.

Result: Urine culture negative except for P. vulgaris by 2nd day of treatment. Response described as "good".

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1. Terramycin may be highly effective even when other antibiotics fail.[1]
2. Terramycin may be well tolerated even when other antibiotics are not.[2]

suggested for: *acute pneumococcal infections, including lobar pneumonia, bacteremia; acute streptococcal infections, including erysipelas, septic sore throat, tonsillitis; acute staphylococcal infections; bacillary infections, including anthrax; urinary tract infections due to E. coli, A. aerogenes, Staphylococcus albus or aureus, and other Terramycin-sensitive organisms; acute brucellosis (abortus, melitensis, suis); hemophilus infections; acute gonococcal infections; lymphogranuloma venereum; granuloma inguinale; primary atypical pneumonia; typhus (murine, epidemic, scrub); rickettsialpox.*

Dosage: 2 to 3 Gm. daily by mouth in divided doses q. 6 h. is suggested for acute infections.

Supplied: 250 mg. capsules, bottles of 16 and 100;
100 mg. capsules, bottles of 25;
50 mg. capsules, bottles of 25.

1. King, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R.B., and Cornely, P. B.: J. A. M. A. 143:1 (May 6) 1950.

2. Herrell, W. E.; Heilman, F. E.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950

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In Memoriam . . .

Alva C. Baker, M. D., Dayton; Illinois Medical College, 1902; aged 79; died August 26. Dr. Baker practiced at Brookville for about 37 years before moving to Dayton ten years ago. Surviving are his widow, a son and a brother.

Byron R. Burgner, M. D., Springfield; Cleveland-Pulte Medical College, 1900; aged 74; died August 31. A former Cleveland physician, Dr. Burgner had been residing in the Masonic Home in Springfield.

Cosper C. Burton, M. D., Ironton; University of Cincinnati College of Medicine, 1910; aged 68; died August 30; member of the Ohio State Medical Association and the American Medical Association through 1946; president of the Lawrence County Society, 1932-1934, and its delegate during the same period. Dr. Burton served his entire medical career in Lawrence County with the exception of time he spent with the Army Medical Corps during World War I. He was a member of the Methodist Church, the Elks Club, and was active in several Masonic orders. He served for several years on the City Health Board and was vice-president and a director of the Etna Building and Loan Company. Surviving are his widow, a son, three sisters and a brother.

Henry Graefe, M. D., Sandusky; New York University College of Medicine, 1908; aged 65; died August 30; former member of the Ohio State Medical Association and the American Medical Association through 1926. Dr. Graefe began his practice in Sandusky in 1910 and continued until 1927 when he retired because of ill health. During World War I he served with the Medical Corps. Surviving are his widow, a son, a daughter and three sisters.

Walter R. Griess, M. D., Cincinnati; Miami Medical College, 1897; aged 74; died August 17; member of the Ohio State Medical Association and a Fellow of the American Medical Association; member of the International College of Surgeons and Fellow of the American College of Surgeons. Dr. Griess served all of his professional career in Cincinnati. He had been president of St. Mary Hospital, chief of the surgical department at Deaconness Hospital, a director and member of the staff of the orthopedic department at Bethesda Hospital and director of surgery at Children's Hospital. He had lectured at the College of Medicine and had served as dean of the College of Pharmacy and as a trustee of the University of Cincinnati. He held memberships in a number of professional societies, also the Cincinnati Club, the Queen City Club and several Masonic orders. Surviving are his widow, two brothers and a sister.

Ralph E. Hatfield, M. D., Cincinnati; University of Michigan Medical School, 1931; aged 45; died August 11 while returning home from a trip in the East; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Hatfield served all of his medical career in Cincinnati with the exception of time spent during World War II in the Navy where he attained the rank of lieutenant commander. From 1935 until 1942 he had served as health commissioner of Norwood. He was a member of the Methodist Church, Maketewah Country Club, Sigma Alpha Epsilon and Alpha Kappa Kappa. Surviving are his widow, two sons, his father, and two sisters.

Frank Lande, M. D., McConnelsville; University of Louisville School of Medicine, 1921; aged 61; died August 28; member of the Ohio State Medical Association and a Fellow of the American Medical Association; member of the American Society of Clinical Pathologists. Dr. Lande was for several years director of Rocky Glen Sanatorium, having resigned last May to resume private practice. He was a veteran of both World Wars and was a member of the Masonic Lodge. Surviving are his widow, a sister and a brother.

Solomon H. Lesinger, M. D., Philadelphia, Pa.; Western Reserve University School of Medicine, 1921; aged 53; died August 11; member of the Ohio State Medical Association through 1930; listed in the 1950 A. M. A. Directory as a member residing in New York City. Dr. Lesinger formerly practiced in Cleveland. He had been on the staff of French Hospital in New York and had joined the staff of Jewish Hospital in Philadelphia only two weeks before his death.

James S. Mariner, M. D., Youngstown; Ohio State University College of Medicine, 1916; aged 64; died August 14; member of the Ohio State Medical Association and the American Medical Association. Dr. Mariner resided in Youngstown and maintained his practice in both Youngstown and Campbell. For 20 years he was health commissioner of Campbell. He was a veteran of World War I. Surviving are a daughter, a son, three sisters and three brothers.

John F. Morey, M. D., Crestline; Eclectic Medical College, Cincinnati, 1923; aged 55; died August 14; member of the Ohio State Medical Association and the American Medical Association. Dr. Morey had practiced in Mansfield from 1929 until about two years ago when he moved to Crestline. He was a member of the American Legion, having served in the Medical

Corps during World War I, and was a member of the Masonic Lodge. Surviving are his widow, a son, a daughter and a sister.

Anna L. Preston, M. D., Marietta; University of Michigan Medical School, 1896; aged 87; died August 29. Dr. Preston had practiced for many years in Marietta. She had retired a number of years ago.

Francis N. Richardson, M. D., Cleveland; Cleveland-Pulte Medical College, 1900; aged 78; died August 18. Dr. Richardson had practiced in Cleveland since completion of his education. He was a member of the Episcopal Church and the Cleveland Yacht Club.

Harley H. Sink, M. D., Columbus Grove; Cleveland-Pulte Medical College, 1903; aged 74; died August 13; member of the Ohio State Medical Association and the American Medical Association; vice-president of the Putnam County Medical Society, 1925, 1929 and 1948; president, 1931 and 1942; delegate, 1943. Dr. Sink had practiced medicine in Columbus Grove for 47 years. In addition to his professional activities, he was active in several Masonic orders and in the Methodist Church. Surviving are his widow, two daughters, a sister and a brother, Dr. O. O. Sink, of Smithfield.

Daniel M. Skinner, M. D., Hamilton; University of Cincinnati College of Medicine, 1912; aged 63; died August 25; former member of the Ohio State Medical Association and the American Medical Association through 1946; Fellow of the American College of Surgeons. Dr. Skinner had practiced in Cincinnati from 1912 to 1917, moving his practice to Hamilton after World War I. He was in service during the First World War. He had retired because of ill health several years ago. Surviving are his widow, two daughters, a sister and two brothers.

Otto E. Weilhamer, Jr., M. D., Cincinnati; University of Cincinnati College of Medicine, 1949; aged 24; died August 26 while on a vacation trip in Mexico City. Dr. Weilhamer had recently completed an internship at Harper Hospital in Detroit. His parents and a sister survive.

St. Luke's Hospital, Cleveland Scheduled October Symposia

Saint Luke's Hospital, 11311 Shaker Boulevard, Cleveland, is offering weekly symposia during October. Following are features of the programs for the meetings of October 11, 18 and 25.

Wednesday, October 11—Peptic Ulcer.

"The Roentgenological Diagnosis of Peptic Ulcer," Dr. H. F. Inderlied, St. Luke's Hospital.

"The Pathology of Peptic Ulcer," Dr. Rafael Dominguez, St. Luke's and Western Reserve University College of Medicine.

"The Evaluation of Recent Medical Concepts of Treatment," Dr. E. E. Woldman, St. Luke's.

"The Evaluation of Recent Concepts of Surgical Treatment," Dr. D. M. Glover, St. Luke's and Western Reserve.

Wednesday, October 18—Congenital Heart Disease.

"Evaluation and Clinical Diagnosis," Dr. A. D. Nichol, St. Luke's.

"Roentgen Manifestations and Diagnostic Aspects," Dr. D. D. Brannan, St. Luke's.

"Special Investigative Procedures," Dr. Charles A. White, St. Luke's and Cleveland Children's Diagnostic Heart Center.

"Types Remedied by Surgical Therapy," Dr. Earle B. Kay, St. Luke's.

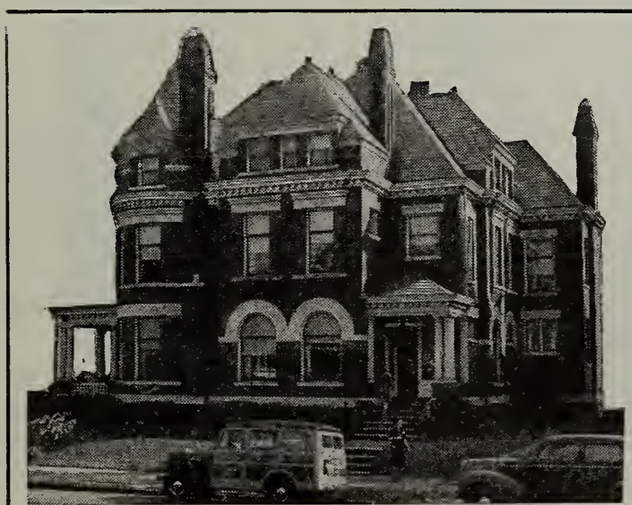
Demonstration of Cases.

Wednesday, October 25—Endocrinology.

"The General-Adaptation-Syndrome and the Diseases of Adaptation," Dr. Hans Selye, University of Montreal.

"Therapeutic Use of ACTH and Cortisone," Dr. Selye.

Presentation of Cases, Dr. E. E. Beard, St. Luke's and Western Reserve.



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Social Security Program Is Greatly Expanded by New Law; Governors Get Model Mental Hygiene Law; Profit on Army X-Rays Not Excessive

The Social Security Law as amended (H.R.6000, signed by the President on August 28), although specifically excluding physicians under the provisions for covered self-employed workers, is of particular interest to doctors who are employers or employees. Also it is of general interest to all because of extensive changes in the whole Social Security structure.

An estimated ten million additional workers will be covered under provisions of the revised act.

Under the new provisions for coverage of self-employed workers, physicians are specifically excluded as are certain other professional persons and farmers.

Domestic workers in private homes who are employed by a single employer for at least 24 days in a calendar quarter for which they receive wages of at least $50 are covered. In general, if a person has a maid for one day in the week she does not come under provisions of the act; if a person has a maid for two or more days in the week, she must be covered.

The Commissioner of Internal Revenue is authorized to prescribe the method by which taxes are to be collected from domestic workers' wages. A "stamp plan" has been suggested, but has not as yet been authorized.

Farm workers and domestic workers in farm homes are covered. A farm worker becomes eligible after he works continuously for one farm operator for three months and then continues to work for him on a full-time basis on at least 60 different days every three months and earns $50 or more in cash wages every three months.

The program has been expanded to include government workers under certain conditions, employees of some non-profit organizations, etc. The term "employee" has been redefined to include many more persons.

New provisions for coverage go into effect on January 1, 1951. Increased benefits went into effect as of September 1, 1950.

Benefits have been increased considerably. For example, the average primary benefit (from which other benefits are determined) was approximately $26. Under the revised act it will be approximately $48.30.

Taxable wages are increased from a maximum of $3,000 to a new maximum of $3,600. The tax rate for employer and employee will be: 1½ per cent through 1953 (same as at present); 2 per cent for 1954 through 1959; 2½ per cent for 1960 through 1964; 3 per cent for 1965 through 1969; and 3¼ per cent for 1970 and subsequent years.

* * *

Federal Security Agency has sent a model mental health law to all state governors. Based on the recommendations of the National Advisory Mental Health Council and the 1950 Governors' Conference, the law was prepared by Dr. Robert H. Felix, director of the National Institute of Mental Health, and Alanson W. Willcox, general counsel of F. S. A.

Grants-in-aid to states represents the largest single item in the Federal Security Agency budget for mental health. Of the $10,000,000 alloted for mental health programs, $3,500,000 goes to states and local communities. Copies of the model law may be obtained from National Institute of Mental Health, Public Health Service, Bethesda 14, Md.

* * *

Despite alleged abuses in fee charges for x-ray examinations of Army inductees, a House subcommittee is satisfied that there was "no unreasonable compensation."

The investigating committee was appointed after it was disclosed that some roentgenologists in the midwest were taking in as much as $1,000 a day, handling as many as 200 chest x-rays per day.

Representative Paul J. Kilday (D-Texas), chairman of the House Armed Services Subcommittee, said at the conclusion of a one-day hearing: "The evidence has not shown unreasonable compensation. The Army soon will be able to make nearly all of its own x-ray examinations. In the case where the fees paid private specialists seem excessive, an effort will be made to reduce them."

Testimony of witnesses at the investigation brought out the following facts:

1. Charges of $5 per each chest picture and interpretation were not excessive in comparison with prevailing charges. Major Gen. George Armstrong said Veterans Administration charged Army $5 for such service, and that V. A. allowed $10 when it contracted with a private roentgenologist. In the Washington area, charges for the same service were as high as $15.

2. Navy is not involved with private roentgenologists; it does not give chest-x-rays until recruits reach training centers, where Navy personnel screen them, using relatively inexpensive processes. Air Force is not involved

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A combined surgical course comprising general surgery, traumatic surgery, abdominal surgery, gastroenterology, proctology, gynecological surgery, urological surgery. Attendance at lectures, witnessing operations, examination of patients pre-operatively and post-operatively and follow-up in the wards post-operatively. Pathology, radiology, physical medicine, anesthesia. Cadaver demonstrations in surgical anatomy, thoracic surgery, proctology, orthopedics. Operative surgery and operative gynecology on the cadaver.

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A full time course. In Obstetrics: Lectures; pre-natal clinics; witnessing normal and operative deliveries; operative obstetrics (manikin). In Gynecology: Lectures; touch clinics; witnessing operations; examination of patients pre-operatively; follow-up in wards post-operatively. Obstetrical and gynecological pathology. Anesthesia. Attendance at conferences in obstetrics and gynecology. Operative gynecology on the cadaver.

UROLOGY

A combined full time course in Urology, covering an academic year (8 months). It comprises instruction in pharmacology; physiology; embryology; biochemistry; bacteriology and pathology; practical work in surgical anatomy and urological operative procedures on the cadaver; regional and general anesthesia (cadaver); office gynecology; proctological diagnosis; the use of the ophthalmoscope; physical diagnosis; roentgenological interpretation; electrocardiographic interpretation; dermatology and syphilology; neurology; physical medicine; continuous instruction in cystoendoscopic diagnosis and operative instrumental manipulation; operative surgical clinics; demonstrations in the operative instrumental management of bladder tumors and other vesical lesions as well as prostatic resection.

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because, like the Navy, it makes chest-x-rays only after recruits have reported for duty.

3. On Defense Department approval, Army instituted the private contract system after it had released most of its surplus World War II x-ray equipment to hospitals and clinics in great need of it. Under peace time conditions Defense Department believed the private contract system would save money.

4. Army now is taking some of its own surplus equipment out of storage, and soon will be in a position to do almost all of its own x-ray examinations.

Ohio Drivers' Licenses Now Expire On Licensee's Birthdays

Drivers in Ohio are purchasing their operators' licenses under a new formula this year. Formerly licenses expired on September 30. The 1950 licenses have this notation: "Expires on Licensee's First Birthday After September 30, 1950."

R. E. Foley, registrar of the State Bureau of Motor Vehicles, issued the following information in regard to the new licenses:

The new licenses are good for three years.

The old license is good until the individual's first birthday after September 30, 1950. In other words, a person whose birthday is on or before September 30 may use the 1950 license until his birthday in 1951.

New licenses may be obtained 30 days before or at any time during the 30 days preceding the individual's birthday.

A person may get the new license at any time for three months following his birthday (but may not drive legally in the meantime).

If a license is not obtained within three months after the driver's birthday, he will be required to take a test the same as a new driver.

University of Michigan Fall Postgraduate Courses

The University of Michigan Medical School, Ann Arbor, is offering the following postgraduate courses during the fall:

"Clinical Internal Medicine," Thursday afternoons, October 5 - December 21; January 10 - April 19.

"Clinical Exercises for Practitioners," Wednesdays—October 18 - December 20.

"Special Pathology of Neoplasms," twice a week—September 26 - November 17.

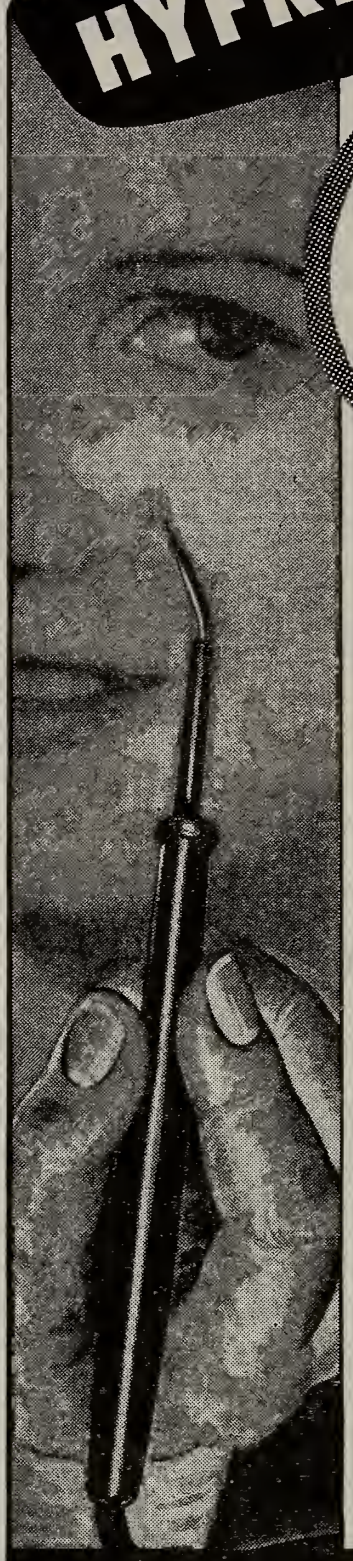
"Diagnostic Methods. Clinical and Laboratory Interpretation," November 7-10.

"Cancer," January 16-19.

Further information may be obtained from Dr. H. H. Cummings, chairman, Department of Postgraduate Medicine, University Hospital, Ann Arbor, Mich.

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Licenses Through Endorsement by State Medical Board

The Ohio State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians, through endorsement of their licenses to practice in other states:

June 16, 1950—Gertrude L. Blackshear, Cleveland, Univ. of Wisconsin; Tibor Agoston, Columbus, Univ. of Budapest; William H. Burrow, Toledo, Univ. of Arkansas; Patrick R. Leonard, Columbus, Univ. of Nebraska.

August 8, 1950—Scharrold O. Adams, Cleveland, Univ. of Michigan; Robert J. Atwell, Columbus, Duke Univ.; Walter Baum, Columbus, New York Univ.; Hugh N. Bennett, Youngstown, Cornell Univ.; Caroline I. Buttrick, Kent, Johns Hopkins Univ.; Robert M. Callicott, Utica, Col. of Medical Evangelists; Lee M. Cattell, Jr., Cleveland, Univ. of Michigan; Ralph A. Clave, Cleveland, State Univ. of Iowa; Jack L. Colgalzier, Dayton, Univ. of Nebraska; Roy A. Edwards, Jr., Columbus, Med. College of Va.

Francis W. Hare, Jr., Akron, Duke Univ.; Ward D. Heinrich, Cleveland, Hahnemann; Robert H. Hines, Minerva, George Washington Univ.; David B. Johns, Cincinnati, Univ. of Pittsburgh; John W. King, Cleveland, Yale Univ.; Sidney A. Kottler, Springfield, Vanderbilt Univ.; James S. Krieger, Cleveland, Univ. of Mich.; John Leland, Centerville, Emory Univ.; Jack M. Mosely, Cleveland, La. State Univ.; Carl J. Nutini, Cincinnati, Univ. of Louisville;

Charles E. Peck, Euclid, New York Univ.; Joseph G. Peil, Middletown, Indiana Univ.; Herbert A. Raskin, Toledo, Wayne Univ.; Oscar D. Ratnoff, Cleveland, Columbia Univ.; John P. Reed, Jr., Columbus, Univ. of Minn.; John W. Robertson, Jr., Cleveland, Howard Univ.; Roger B. Scott, Cleveland, Johns Hopkins Univ.; Benson R. Snyder, Cincinnati, New York Univ.; George A. Streeter, Wickliffe, Johns Hopkins Univ.; Dorothy B. Suyemoto, Cincinnati, Univ. of Michigan;

Samuel A. Trufant, Cincinnati, Tulane Univ.; Glen B. Van Atta, Belle Center, George Washington Univ.; Robert E. Wybel, Akron, Harvard; Genevieve G. Dutton, Athens, Medical College of Virginia; Wayne W. Dutton, Athens, Medical College of Virginia; Ralph L. Maddox, Hicksville, College of Medical Evangelists; Norman M. Minde, Youngstown, Univ. of Buffalo; Fiorindo A. Simeone, Cleveland, Harvard; Samuel Gingold, Cincinnati, Syracuse; Lewis D. Telle, Cleveland, Univ. of Ill.

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New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since August 4, 1950. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ALLEN COUNTY
Hugh J. Savage, Lima

FAIRFIELD COUNTY
Rudolph W. Pedigo, Lancaster

FRANKLIN COUNTY
Thomas J. Trythall, Jr., Groveport

GALLIA COUNTY
Oscar W. Clarke, Gallipolis
John C. Markley, Gallipolis
Franklin H. Schaefer, Gallipolis

HAMILTON COUNTY
Arthur T. Evans, Cincinnati
Melvin B. Fishman, Cincinnati
John M. Glenn, Cincinnati
John N. Hannum, Cincinnati
Melvin A. Lucas, Cincinnati
James Mackay McCord, Cincinnati
Hilmer W. Neumann, Cincinnati
R. C. Pogge, Cincinnati
Elmer A. F. Schlueter, Cincinnati
Paul A. Schuster, Cincinnati
Roland F. Shirley, Cincinnati
Stanley H. Willer, Cincinnati

JEFFERSON COUNTY
James L. Childs, Steubenville

LUCAS COUNTY
Christopher G. Palans, Toledo
James E. Schaal, Maumee

MAHONING COUNTY
Robert J. Heaver, Youngstown

MARION COUNTY
Robert C. Campbell, Marion
A. J. Willey, Marion

MEIGS COUNTY
William H. Jeric, Pomeroy

RICHLAND COUNTY
Max D. Garber, Mansfield

TUSCARAWAS COUNTY
Paul W. Ebert, Dover
Max L. Rohrer, New Philadelphia

Clinic in Cleveland Matches Cardiacs to Job Demands

The Work Classification Clinic opened recently in Cleveland under direction of the Cleveland Heart Society and after approval by the Cleveland Academy of Medicine. Principal function of the clinic, the second of its kind in the United States, is to evaluate the working capacity of persons stricken with a heart ailment.

The clinic performs the following four functions: Appraises the cardiovascular system of the victim; analyzes the total physical capacity of the individual; analyzes the demands of the specific job; and strives to match the physical capacity of the cardiac to the job demands.

Dr. Herman K. Hellerstein, research cardiologist at University Hospitals, is director of the unit. A panel of specialists sits twice a week to review cases. The panel consists of Drs. Edward M. Kline, Harold Feil and A. Carleton Ernestene.

It is emphasized that the clinic offers neither diagnostic nor therapeutic services.

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William H. Scroggins III

Ninth District To Convene in Scioto County, Oct. 12

The Hempstead Academy of Medicine will be host to the Ninth District of the Ohio State Medical Association with a scientific program on Thursday, October 12. The meeting will be held at the Chez Paree in Wheelersburg, which is a few miles east of Portsmouth on Highway 52.

The one-day course on "Mother and Child" will be conducted by Dr. Thomas E. Shaffer and Dr. Allan C. Barnes, both of the Ohio State University College of Medicine, Columbus. Dr. Shaffer is professor of pediatrics, director of student health at the University and consultant to the Neonatal Nurseries of University Hospital. Dr. Barnes is professor and chairman of the Department of Gynecology and Obstetrics.

The following features are scheduled:

2 p. m.—"The Infertile Couple," the practical office approach to the diagnosis and treatment of the sterile couple—Dr. Barnes.

3 p. m.—"The Rh Negative Mother." Specifically and definitely what to do and what to recommend for the pregnant woman who is Rh negative; management of the newborn in these cases—Dr. Shaffer.

4 p. m.—"Dietary Management of Pregnancy and Its Complications." No chemistry, but what should be eaten and why; how these patient instructions can be modified for some of the commoner complications of pregnancy—Dr. Barnes.

5 p. m.—"Problems of the Neonatal Period." The new-born child and some of its emergency complications and congenital difficulties—Dr. Shaffer.

6:30 p. m.—Dinner.

8 p. m.—"The School Child." The Ohio law on school health examinations and how it affects the practitioner. The tests that are of value and those that are not—Dr. Shaffer.

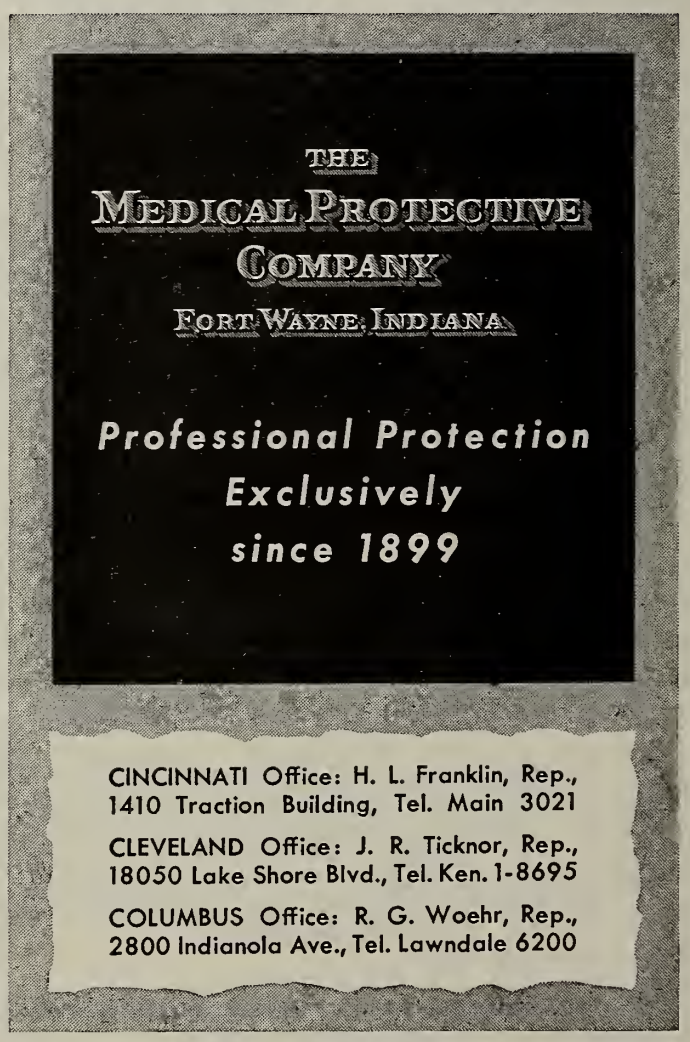
9 p. m.—"The Use of the Female Sex Hormones in General Practice." The endocrine products and programs that can be expected to work, and those which have little reasonable chance of helping the patient—Dr. Barnes.

The U. S. Public Health Service reported the following figures on prevalence of poliomyelitis in Ohio: Week ending September 2, 1950, 98 cases; week ending September 3, 1949, 171 cases; total (beginning with the 12th week of each year) for 1950, 445; total for 1949 (same period), 886; five-year median, 1945 - 1949, (same period) 304.

According to statisticians of the Metropolitan Life Insurance Company, there are more than 250,000 diabetics in the labor force in this country at the present time.



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Northwestern Association Schedules Program at Lima, October 17

The Northwestern Ohio Medical Association has scheduled its annual scientific program at Lima on October 17. The meeting will be held at the Shawnee Country Club with registration beginning at 9:30 a. m. The group has arranged with a team from the University of Wisconsin Medical School to conduct the scientific sessions.

Following are features of the program:

"The Third Stage of Labor—Normal and Abnormal," Dr. John W. Harris, professor and chairman, Department of Obstetrics and Gynecology.

"The Chemosurgical Method for the Microscopically Controlled Excision of External Cancer," Dr. Frederic E. Mohs, associate professor of chemosurgery.

"The Role of Proctoscopy in General Practice," Dr. Karver L. Puestow, professor of clinical medicine.

"Drug Allergy," Seymour B. Creapea, assistant professor of internal medicine and chairman of the Department of Allergy.

"The Growing Field of Postgraduate Education," Dr. Robert C. Parkin, coordinator of graduate medical education.

Communications in regard to the meeting should be directed to Dr. Ralph E. Rasor, president of the Northwestern Ohio Medical Association, or Dr. E. H. Evans, secretary, both of Findlay.

Medical Advisory Committee for Blood Bank Named

A regional medical advisory committee to the Red Cross Blood Program in this area was organized at a meeting held September 14, at the Seneca Hotel. Attending the meeting were chairmen of the medical advisory committees in the 23-County area serviced by the Columbus Regional Blood Center.

Elected to serve on the executive committee of the regional medical advisory committee are Dr. Harve M. Clodfelter, Columbus, Chairman; Dr. J. G. Parker, Delaware, Vice-Chairman; Dr. T. W. Geoghegan, Fostoria; Dr. K. F. Lowry, Troy; Dr. J. M. Goodman, Athens; Dr. Robert W. Wolford, Mansfield; Dr. John C. Drake, Mt. Vernon; Dr. H. M. Crumley, Chillicothe.

The over-all policies for the medical phases of the Red Cross Regional Blood Program are made by the medical advisory committee for each county. The purpose of the regional advisory group is to coordinate these policies.

Dr. Clodfelter has served on the medical advisory committee of the Blood Center prior to its opening on December 7, 1948.

There are 27 Red Cross chapters in this regional area.



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American College of Physicians Midwest Meeting, Nov. 18

The Midwest Regional Meeting of the American College of Physicians will be held at the Memorial Union Theater on the campus of the University of Wisconsin, Madison, Saturday, November 18.

Registration will begin at 8 a. m. and the scientific meetings will be followed by a social hour and dinner to be held at the Loraine Hotel beginning at 5:30 p. m.

The day will be filled by the presentation of scientific papers. In addition, a scientific exhibit will be provided at the Memorial Union Theater.

All physicians and their wives are invited. Entertainment has been provided for the ladies.

Additional information may be had from Dr. Robert C. Parkin, coordinator, The University of Wisconsin Medical School, Madison, Wisc. Reservations for luncheon and dinner should be made through Dr. H. M. Coon, 1300 University Ave., Madison 6, Wisc.

Eighth District Schedules Meeting At Newark, October 5

The fall meeting of the Eighth District of the Ohio State Medical Association has been scheduled at the Moundbuilders Country Club, Newark, Thursday, October 5.

The following features have been announced:

1:30 p. m.—"Principles of Topical Therapy in Dermatology," Dr. Arthur J. Tronstein, Newark.

2:30 p. m.—"Treatment of the Skin and Skin Lesions by X-ray and Radium," Dr. Arnold D. Piatt, Newark.

3:30 p. m.—"Medical Aspects of Atomic Warfare," Dr. George L. Sackett, Cleveland.

Business meeting following scientific discussion with Dr. James B. Johnson, Newark, District President, presiding.

6:30 p. m.—Banquet with the Auxiliary.

Fellowship Grants

Two Ohio men were awarded fellowship grants, part of a $261,700 Federal grant. A total of 89 students in 20 states and two foreign countries received fellowships awarded on recommendation of the Fellowship Boards of the six National Institutes of Health (Heart, Cancer, Mental Health, Experimental Biology and Medicine, Microbiology, and Dental).

Ohio recipients are Harvey C. Knowles, Children's Hospital Research Foundation, Cincinnati, $3,600, determination of changes in concentration of intracellular electrolytes in severe diabetic and other states; and Max Schlamowitz, Ohio State University, $3,600 investigation of the properties and biological functions of the galactogens.

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GYNECOLOGY—Intensive Course, two weeks, starting Oct. 23. Vaginal Approach to Pelvic Surgery, one week, starting Nov. 6.

OBSTETRICS—Intensive Course, two weeks, starting Nov. 6.

MEDICINE—Intensive General Course, two weeks, starting Oct. 2. Gastro-enterology, two weeks, starting Oct. 16. Gastroscopy, two weeks, starting Oct. 23. Electrocardiography & Heart Disease, four weeks, starting Oct. 2.

DERMATOLOGY—Formal Course, two weeks, starting Oct. 16. Informal Clinical Course every two weeks.

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Activities of County Societies . . .

CLINTON

Members of the Clinton County Medical Society and their wives held a dinner meeting at the Snow Hill Country Club on Aug. 2. Dr. Edward B. Headley, new commissioner of the Clinton County Health District, and Mrs. Headley were guests at the meeting. Following a business session, Dr. Kelley Hale, Wilmington, showed color pictures of his recent trip to the West.

DARKE

"British Socialism and America's Number One Lesson" was the subject of a discussion by Dr. John Martin, Dayton, at the Sept. 19 meeting of the Darke County Medical Society in Greenville. The dinner meeting was attended by members, their wives and guests.

GUERNSEY

The regular meeting of the Guernsey County Medical Society was held Sept. 7 at the Cambridge State Hospital, with Dr. Reo M. Swan, president, in the chair, and 16 members present.

Dr. Arthur T. Hopwood, superintendent of the hospital, was in charge of the scientific progam and had invited members of the Society to be his guests for luncheon. A fine meal was enjoyed by all.

After luncheon, members were conducted to one of the spacious assembly rooms of the hospital for business and scientific meetings.

Contents of some important bulletins from the A. M. A. and the Ohio State Medical Association were called to the attention of members by the secretary. Members delinquent in paying their A. M. A. dues for 1950 were reminded. The probable order of sequence in which doctors would be called by the Armed Forces was mentioned.

Doctors and their families were reminded of the importance of being registered so as to be able to vote in the coming election.

Next came the scientific portion of the program, in charge of Dr. Hopwood, ably assisted by members of his resident staff, Drs. Martin and Latta. Each doctor presented two illustrative cases of mental illness along with pertinent history and examination findings. The patients whose cases had been presented were brought into the room and leading questions asked of them by the presenting doctors.

The following cases were represented:

1. Two cases of paresis—one who had received early and adequate antiluetic therapy (penicillin, fever, mapharsen and bismuth), and another whose paresis had existed for about five years before proper therapy. The early case had apparently made a good recovery whereas the late case had shown but little improvement.

2. Cases of cerebral arteriosclerosis and of Altheimer's disease (organic psychosis).

3. Cases of chronic delirium tremens and schizophrenia.

At the conclusion of this fine meeting, the president expressed the thanks of the Society for Dr. Hopwood's hospitality.—Gordon Lawyer, M. D., Sec'y.-Treas.

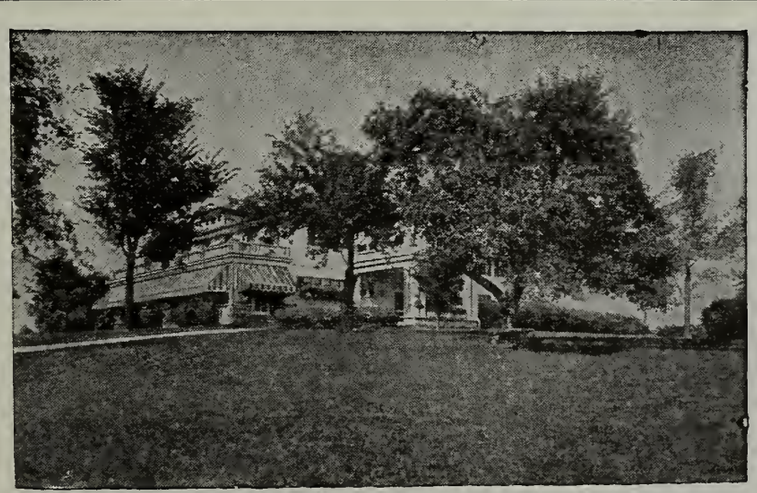
LORAIN

"Current Problems Affecting the Ohio Medical Association," was the subject of a discussion by Dr. Fred W. Dixon, Cleveland, President-Elect of the Association, at the Sept. 12 meeting of the Lorain County Medical Society. Memorial addresses in behalf of the late Dr. Benjamin Carlson and the late Dr. Robert Hancock were given by Dr. Peter A. Etzkorn and Dr. J. T. Fawcett, respectively.

MIAMI

Medical-economic problems of the medical profession were discussed at the Sept. 8 meeting of the Miami County Medical Society in the Stouder Hospital, Troy.

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MAHONING

Dr. M. A. Blankenhorn, professor of medicine, University of Cincinnati College of Medicine, spoke at the Sept. 19 meeting of the Mahoning County Medical Society in the Elks Club.

Announcement of three coming meetings were made as follows:

Oct. 17 meeting guest speaker will be Dr. A. R. Moritz, professor of pathology, Western Reserve University School of Medicine.

Nov. 14 meeting speaker will be Dr. Howard F. Root, member of the Joslin group in Boston and president of the American Diabetic Society. The meeting will coincide with the national Diabetic Detection Week drive.

The December meeting will feature the election of officers.

PUTNAM

Matters relating to organization and the military emergency were discussed at the Sept. 5 meeting of the Putnam County Medical Society at Columbus Grove. The next meeting will be held at Witteborg's Restaurant, Columbus Grove, at which time the 50-Year Pin and Certificate of the Ohio State Medical Association will be presented to Dr. Charles W. Bird, of Continental.

SUMMIT

Dr. Spafford Ackerly, professor and chairman of the Department of Psychiatry, University of Louisville School of Medicine, was guest speaker at the Sept. 5 meeting of the Summit County Medical Society. His subject was "The Problem of the Adolescent." The meeting was held in the Nurses' Home of the Akron City Hospital.

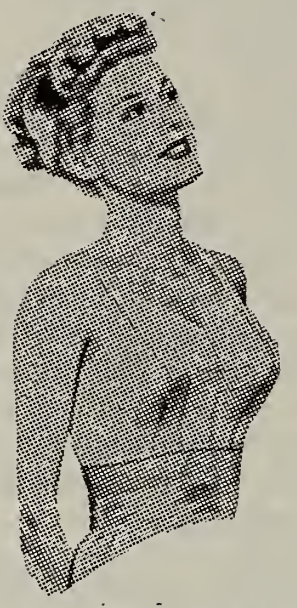
TUSCARAWAS

Members of the Tuscarawas County Medical Society and Auxiliary were guests at the country home of Dr. D. D. Hostetler, Sugarcreek, for an outing on Aug. 9.

Retirement of Assistant Surgeon General R. E. Dyer, director of the National Institutes of Health, has been announced. He has accepted an appointment as director of research at the Robert Winship Clinic of Emery University Medical School, Atlanta, Ga.

The Schering Corporation has announced the establishment of another Research Fellowship in Endocrinology at Rutgers University. The grant is valued at $2,300, and is intended to support fundamental research by graduate students in the field of steroid hormones.

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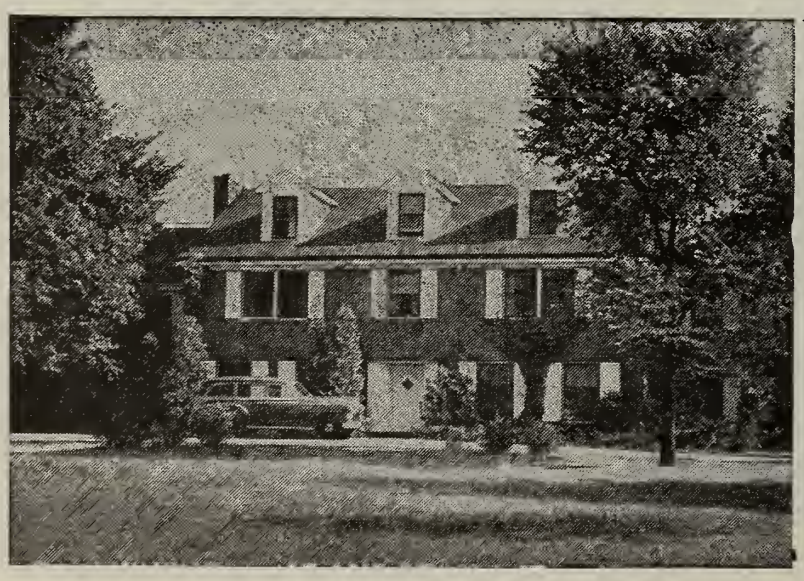
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Past-President—Mrs. C. W. Kirkland, 4805 Guernsey Street, Bellaire

CLARK

Mrs. E. W. Keefer, chairman of public relations for the Clark County Auxiliary, supervised the auxiliary's medical exhibit at the Clark County Fair in August. Assisting on the committee were Mrs. W. D. Beasley, Mrs. E. R. Hargett, Mrs. G. F. Ross, Mrs. George Smith and Mrs. John Summers. Members of the auxiliary turned out in force to lend assistance. The care of babies during their first year of life was a feature of the exhibit. The Fall "get-together" of the group will be held at the home of Mrs. Harold Shanklin on Sept. 18.

HAMILTON

Mrs. Richard D. Bryant, president of the Woman's Auxiliary to the Hamilton County Medical Society, was hostess to her new board early in September at a luncheon at the Cincinnati Woman's Club. Plans were made to sponsor a dinner-dance for the group's Scholarship Fund. A similar dinner-dance held this past year enabled the Auxiliary to give $200 to the University of Cincinnati College of Nursing and Health, and $1,000 to the University of Cincinnati College of Medicine—half the amount goes to the Medical College Library and half to aid medical education through scholarships.

MAHONING

The Mahoning County Auxiliary kept actively engaged during the summer months in helping toward the defeat of Reorganization Plan No. 27. Under supervision of its president, Mrs. William H. Evans, the members cooperated with its County Society by mailing some 3,000 letters and circulars protesting the passage of this bill. The group also has made an intensive effort to get all county members, their wives and adult members of their families registered so that they will be eligible to vote in November. An informal dance was scheduled for Sept. 23, proceeds of which go toward the Nurses' Scholarship Fund.

Mrs. Evans' official family includes: Mrs. Paul J. Mahar, vice-president; Mrs. Samuel Zoss,

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treasurer; Mrs. A. E. Rappaport, secretary; Mrs. John Rogers, corresponding-secretary; Mrs. C. A. Gustafson, president-elect. This year marks the tenth anniversary of the organization of the Mahoning County Auxiliary.

ROSS

The Woman's Auxiliary to the Ross County Academy of Medicine, entertained the state president, Mrs. George W. Cooperrider at its first dinner meeting of the season Sept. 7, at the Warner Hotel. Other guests at the meeting included Mrs. W. F. Heine, president of the Pickaway County Auxiliary, Mrs. Ray Carroll of Circleville and Mrs. Frank J. Lacksen of Columbus. Mrs. Walter E. Kramer, president, conducted the business session that followed the dinner, and introduced Mrs. Cooperrider who gave highlights of the national convention held in June in San Francisco. The speaker also discussed auxiliary plans for the coming year and gave suggestions for work and projects of the local group.

Mrs. Heine spoke on the activities of the Pickaway group and told of its accomplishments during the past year. Mrs. G. Howard Wood, chairman of the Nurses' Loan Fund, reported on the meeting of her committee. Other committee chairmen gave reports.

According to a census made January 1, 1950, by the Public Health Service, 25,081 public health nurses were in public work in 1950, which was 1,708 more than the number reported in 1949.

COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Netherland Plaza, Cincinnati, April 24-26, 1951.

A. M. A. Clinical Session, Cleveland, December 5 - 8.

Eighth Councilor District Fall Meeting, Moundbuilders Country Club, Newark, October 5.

International College of Surgeons, U. S. Chapter, Annual Assembly, Cleveland, October 31-November 3.

Medina Community Hospital, Scientific Program, Westfield Country Club, LeRoy, October 4.

Sixth Councilor District Postgraduate Day, St. Francis Hotel, Canton, October 4.

Ninth Councilor District Fall Meeting, The Chez Paree, Wheelersburg, October 12.

Northwestern Ohio Medical Association, Annual Scientific Program, Shawnee Country Club, Lima, October 17.

Ohio Society of Allergists, Seneca Hotel, Columbus, October 7 - 8.

Second District Annual Program and Banquet, Biltmore Hotel, Dayton, October 18.

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WANTED: Registered Medical Technician, Dayton; Private Laboratory. Answer, Box 619, Ohio State Medical Journal.

Columbus—Dr. Emmerich von Haan recently was promoted to the rank of Colonel in the Army Medical Corps Reserve. He is commanding officer of the 49th Evacuation Hospital, a Reserve unit affiliated with Ohio State University. His commission was presented by Brigadier General Edward T. Kirkendall, Columbus, senior Reserve physician in Ohio.

According to experience among industrial policy holders of the Metropolitan Life Insurance Company, the lowest first-quarter death rate for influenza and pneumonia was established for the first three-months of this year. This is in spite of a widespread outbreak of both diseases.

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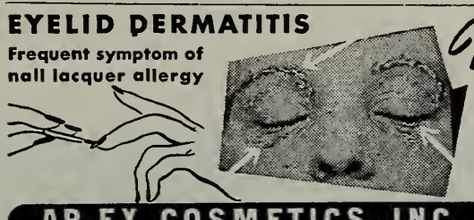
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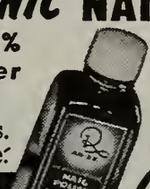




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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Santa Claus, M. D., by W. M. Bauer, M. D., ($2.75. *The Bobbs-Merrill Co., Indianapolis 7, Ind.)* states the physicians' side of the controversy on compulsory prepayments for sickness benefits. The Doctor of Health Education for the American Medical Association makes a good case for the efficiency of our present American medical care program on basis of present day health. He explodes the myth of our poor health. Here you will find the answers to all the misinformation put out by those who propose to take over the medical care of America, whatever their motive may be. Here are also the details of the positive constructive steps that are being taken to help the individual solve his own medical care problems. All the ammunition that a physician needs to defend himself, his profession, and his country from socialization after the pattern of Karl Marx.

The First Anesthetic—The Story of Crawford Long, by Frank K. Boland, M. D. ($3.00. *University of Georgia Press, Athens, Ga.),* is the work of a professor of surgery at Emory University who has worked tirelessly to establish Long's priority. Dr. Boland has produced a persuasive and readable story.

Has Your Child a Cleft Palate? (Apply. *Commission for Handicapped Children, Springfield, Illinois),* is the story of the cleft palate and of how children who have this condition may be helped medically and educationally. The pamphlet has been prepared for use in connection with the training given by properly qualified speech correctionists.

Acrylic Plastics in Dentistry, by Jacob R. Schwartz, D. D. S., ($11.00. *Dental Items of Interest Publishing Co., Inc., Brooklyn, N. Y.)* brings us up to date on this important question of plastics.

Microphthalmos and Anophthalmos With or Without Coincident Oligophrenia, by Torsten Sjogren and Tage Larsson, *(Ejnar Munksgaard, Norregade 6, Copenhagen),* is a clinical and genetic-statistical study, presenting 137 cases of patients with blindness.

Compulsory Medical Care and the Welfare State, by Melchior Palyi, ($2.00. *Nat'l. Institute of Professional Services, Inc., Chicago, Ill.),* is an analysis based on a special study of governalized medical care system on the continent of Europe and in England. The first comprehensive survey on compulsory medical care in various countries. The emphasis is on the major economic, political, and social implications and resultants. The publishers are interested in wholesaling it to you. You will do a service if you buy a copy for your more influential patients.

Research in Medical Science, edited by David Ezra Green, Ph. D., and W. Eugene Knox, M. D., ($6.50. *MacMillan Company, New York City),* presents some 26 different aspects of medical research reviewed by a representative of the particular field. So we have an intimate picture of the methods and problems which inculcate medical research.

The Pioneer Doctor in the Ozarks White River Country, by Amy Johnson Miller, ($2.50. *Burton Publishing Company, 722 Main St., Kansas City 2, Mo.),* is a daughter's portrait of her father, John Cable Breckenridge Johnson, M. D. It is not Art but it is good local history. More of us should take time to record the events in the lives of our families so that future historians of our Universities can get a true picture of our times. If we have the money we should have the records published and distributed to the younger members of our clan. If we are short of funds, I suggest that we forego the monument over our graves, or ask our friends to forego the flowers and give the money to a fund for the publication of our manuscript. If we are entirely short of funds for this purpose, prepare the manuscript and turn it over to the Historical Society who will keep it available for future scholars. Mrs. Miller is to be congratulated for her effort. We who are interested in local history know that without such manuscripts future scholars will not have the necessary materials with which to do their work. There is no better source of knowledge about our past than what Society did to its physicians, and what its physicians did for it.

Freud: Dictionary of Psychoanalysis, edited by Nandor Fodor and Frank Gaynor, ($3.75. *The Philosophical Library, Inc., New York City),* is an attempt to preserve the sacred memory of the master by giving us his definitions of terms. Are we to infer that there can be no change? Reminiscent of Samuel Thomson.

Lipidoses: Diseases of the Cellular Lipid Metabolism by Siegfried J. Thannhauser, M. D., ($12.00. Second Edition. *Oxford University Press, New York City).* While the book gives us the chemical facts, the author insists that physical and chemical means in medicine should

never replace, but rather supplement, the art of seeing, feeling, and listening. The idea of "engineer of health," he says, "is a deplorable misconception of the physician of the future." The volume is another revised reprint from Oxford Loose-Leaf system.

Penicillin and Streptomycin in the Treatment of Infections, by Chester S. Keefer, M. D., and Donald G. Anderson, M. D., ($2.50. *Oxford University Press, New York City)* is a separate reprint from the Oxford Loose-Leaf Medicine.

Monographs on Surgery, 1950, edited by B. Noland Carter, M. D., Cincinnati General Hospital, ($12.50. *Thomas Nelson & Sons, New York City),* represents a distinct change in policy of the publisher. Instead of the loose-leaf form, a bound volume is to be offered annually.

Gynecologic Diagnosis, by Robert Tauber, M. D., ($6.00. *Thomas Nelson & Sons, New York City)* is devoted solely to diagnostic matters, including 30 problems offered for mental exercise and stimulation in addition to the practical training in the art of diagnosis.

Proctology in General Practice, by J. Peerman Nesselrod, ($6.00. *W. B. Saunders Co., Philadelphia, Pa.),* is the fruit of years of labor in the study, laboratory, operating room, at the bed-side, and in the consultation room, by one of our best specialists in the field.

Malaria: The Biography of a Killer, by Leon J. Warshaw, M. D., ($3.75. *Rinehart & Co., New York City),* is the history of the world's greatest killer.

Essential Urology, by Fletcher H. Colby, M. D., ($8.00. *Williams & Wilkins, Baltimore, Md.),* is a text based upon the subject as practiced at the Massachusetts General Hospital.

Diseases of the Eye, Ear, Nose, and Throat. A Text for Nurses, by Albert P. Seltzer, M. D., ($4.00. *McGraw-Hill Book Co., New York City),* is based upon not only the author's years as a teacher of nurses, but also by the writings of many specialists, in an effort to give a sound basis for the essential information of the student nurse.

The Mystery of Sex and Race Regeneration, by R. Swinburne Clymer, M. D., ($3.00. Fourth Edition. *Philosophical Publishing Co., Quakertown, Pa.),* presents the spiritual approach of "an old fashioned" clergyman with an M. D. degree. The author is positive in his condemnation of all the "evils of sex."

Medical Entomology, by Robert Matheson, ($7.50. Second Edition. *Comstock Publishing Co., Ithaca, N. Y.),* has assumed much greater importance than its first edition. In the light of our World War II experience, insects have become recognized as having an important role in human welfare.

Magic Cloak, A Contribution to the Psychology of Authoritarianism, by James Clark Maloney, M. D., ($5.00. *Montrose Press, Wakefield, Mass.),* is actually a discussion of the unconscious influences in the choice of our occupation. Most individuals wear a magic cloak. "Out of fear and helplessness, in a terror-ridden world, the individual pulls about his shoulders the character of a supreme being. The cloak fits so snugly that sooner or later he becomes unable to distinguish between himself and the illusionary assumption of majesty."

How To Stop Killing Yourself, by Peter J. Steincrohn, M. D., ($2.95. *Wilfred Funk, Inc., New York City),* gives a new slant to the importance of rest, contemplation and relaxation. An excellent technique for the job it is intended to do.

Breast Deformities and Their Repair, by J. W. Maliniac, M. D., ($10.00. *Grune & Stratton, New York City),* presents the knowledge and experience of a distinguished plastic surgeon. Most of us are not interested in this subject; First, because we are ignorant of what is being done, and, Secondly, because those disfiguring enlargements, not associated with disease, do not interest us because we have been trained to think of disease, not health or happiness. The book is illustrated with 116 persuasive photographs, many of the "before and after" variety. This book should be in the library of every hospital and every surgeon who deals with the human breast.

A Primer For Diabetic Patients, by Russell M. Wilder, M. D., ($2.25. Ninth Edition. *W. B. Saunders Company, Philadelphia, Pa.),* presents an outline of treatment for diabetes with diet and insulin, including directions and charts for the use of physicians in planning diet prescriptions as practiced at the Mayo Clinic.

Food For Better Living, by Irene E. McDermott, Mabel B. Tulley, and Florence Williams Nicholas, ($2.60. *J. B. Lippincott Company, Philadelphia, Pa.),* is based on the conviction that study of food by high school students should stress the essential relationship between the adequate handling of the food problem in the home, and the good family life.

Selected Questions and Answers, Vol. 3, ($3.00. *The Amer. Medical Association, 535 N. Dearborn St., Chicago, Ill.)* have been taken from the "Queries and Minor Notes" Department of *The Journal of The A. M. A.* Five hundred and seventeen pages are listed under 42 headings. If you do not keep a complete file of *The Journal* in your library, then you will find this volume most handy as a book of reference. Again I feel that busy interns should have a copy in their library.

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JONATHAN FORMAN, M.D., *Editor*

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The Problem of the Cross-Eyed Child

LEWIS V. KOGUT, M.D.

THE subject of cross-eye is too extensive to be more than touched upon in a paper of this type. Although the literature in various periodicals on all phases of cross-eye is abundant, the purpose of this paper is not directed primarily to the ophthalmologist, but to the pediatrician and to the general practitioner who first come in contact with the cross-eyed child. The various diagnoses, types, and severity of cross-eye present is outside the realm of this paper. It is the aim of the writer to present the subject with sufficient simplicity so that knowledge of this subject will be comprehended by all observers who are concerned with the promotion of normal visual function in this particular aspect. It should be emphasized that, if results of any value are to be obtained, the work should be carried out by those who have special knowledge of the subject. Only too often have patients been seen who received treatment by unqualified persons and by whom definite harm had been done.

Cross-eye or squint is essentially the involvement of the extraocular muscles and of the sensory-psychic visual apparatus. In general, it may be said that any obstruction to proper fusion of stimuli from the two eyes may cause a squint. This may be caused by interference with the formation of the image on the retina, or its perception, by opacities in the various parts of the eye, by anatomical and developmental defects of the ocular muscles, the retina, and optic nerve; by inflammatory changes, and by trauma causing direct or indirect injury to the central nervous system. By far the most common cause is an error of refraction, especially marked differences in refraction between the two eyes. Severe farsighted patients who attempt to compensate for the error by strong accommodation, in so doing over-converge either eye.

Submitted March 13, 1950.

The Author

● Dr. Kogut, Cleveland, Ohio, is a graduate of Stritch School of Medicine of Loyola Univ., Chicago, 1934; diplomate, The Amer. Bd. of Ophthalmology, 1940; fellow, Amer. Academy of Ophthalmology and Otolaryngology. On courtesy surgical staff, St. Alexis Hosp. and Marymount Hosp., Cleveland.

The onset of cross-eye in early or late childhood presents a problem of management to the parent and to the physician. The cross-eyed child is not only unattractive in appearance, but also suffers physiologically, from the lack of binocular vision, fusion, and depth perception. As soon as the parents are aware of this condition, they seek consultation from various sources, some professional but more often non-professional. This latter advice is frequently misleading, and erroneous. Any suggestion that a child will outgrow this condition is dangerous information that may result in irreparable damage, such as mental suffering on the child's part, mal adjustment in society, and the loss of useful vision.

DEVELOPMENT OF EYES

At birth most babies are farsighted. This is soon outgrown and at the age of eight years the eyes reach a normal state. If the develop-

ment of the eyes falls behind that of the rest of the body, the child remains farsighted for the rest of his life. In other words farsightedness is due to a relatively short antero-posterior diameter of the eyeball. If this lengthening process of the eyeball continues beyond the normal state, it then produces a condition of nearsightedness. A farsighted child usually has normal vision in that he may see 20/20 or even better, but this conditon requires continuous extra effort on the eyes to secure normal vision. If this process of constantly focusing excessively is more than usual, the ciliary muscle becomes very powerful. In the process of this accommodation there is a tendency for the eyes to turn in or to converge more than usual. This is one of the causes for cross-eye, particularly in children from the ages ranging from one to four years. Relaxation of this muscle is seldom attained unless some drug as atropine is used in the eyes. This produces a dilation of the pupils and the muscle of convergence is relaxed and this may reduce the deviation entirely. If this is the case the eyes become straight and glasses are the cure instead of surgery. Sometimes this condition may be corrected by glasses which eliminate the excessive focusing. But if the farsightedness is only a precipitating factor and not the entire cause, glasses will straighten the eyes only partially or temporarily. The remainder of the crossing requires correction by other methods.

A child learns to use his eyes together in fusion at about the age of five years. This consists in bringing images of objects together for presentation to the brain as one image. If the eyes can be straightened before fusion takes place, they will work together and binocular single vision is maintained which is the normal process. This is one of the chief reasons why the cross-eyed child should be corrected early, that is, before the age of five. **To advise the parents at this stage to let the child alone, and presume that he will grow out of it, means not only a lost eye as far as a useful functioning organ is concerned, but usually means resorting later to tedious surgery, which if successful will only result in a cosmetic correction—that is, "a straight eye"; however, the vision is lost.**

DETERIORATION OF CROSS-EYE

It is commonly believed that a cross-eyed individual sees double. This is not true because only the straight or the "good eye" is used to fix on objects. Since the cross-eye or the "poor eye" is not used because it is not in the line with the "good eye" for binocular vision, the eye gradually loses vision through disuse or failure to develop vision. Before the child can learn how to fuse, this lost vision must be restored and fortunately it will return if the child is forced to use the poor eye. This is done by covering the good eye with a patch. This should be constant for a definite period in order that the vision may be restored as quickly as possible because time is of the utmost importance. If the vision has been restored in the weaker eye by patching and by glasses and the eyes are still not straight in a period of six months then surgery is almost invariably required to attain the cure.

In another type of cross-eye the child may use one eye and then the other but never both together. The child uses one eye to see and the other crosses and vice versa. In other words, the eye will alternate for vision while its mate will always cross. In this type, the vision in each eye is preserved because each eye is stimulated to see, but fusion is absent. Only one eye fixes and therefore the eyes never work together. To maintain fusion the eyes must have simultaneous macular perception, in other words, the size of the two images presented to the brain must be identical.

USE OF EXERCISES LIMITED

There is much erroneous information regarding the use of eye exercises. It is only the patient with a certain type of cross-eye, whose eyes are crossed slightly when wearing glasses, that can be cured by eye exercises alone. Eye exercises do not strengthen weak muscles. Their sole function is to teach the child to use his two eyes together as a team. There is nothing more futile than for one whose eyes are severely crossed, to take extensive exercises week after week in the hope that the eyes will miraculously become straight.

CONCLUSION

In conclusion it can be said that the amount of lost vision caused by cross-eye is in direct ratio to the duration of the squint. Correction of this defect of the eyes can be attained by glasses, eye exercises or surgery. Patient, parent, and physician must be aware that only early and accurate diagnosis is most urgent to obtain satisfactory results. Proper professional consultation is able to indicate the type of therapy that may be required for this condition. Treatment should be instituted as soon as the child shows any signs of turning of the eyes.

Aureomycin and chloramphenicol have become established as highly effective broad spectrum antibiotics. Terramycin, a third member of this group of compounds, possesses highly activity against a wide range of infections. It has not exhibited toxicity, and side-effects have not constituted a problem in therapy. Its spectrum of activity most closely resembles that of aureomycin.—Vernon Knight, M. D., N. Y. State J. M.

Relation of Blood Cholesterol to Basal Metabolic Rate*

R. W. KISSANE, M. D., RICHARD BROOKS, M. D., and THOMAS E. CLARK, M. D.

THERE is a widespread impression that a relationship exists between basal metabolic rate and blood cholesterol, especially low basal metabolic rates and high blood cholesterol. This has been the result of various statements that have appeared in the literature.[1, 2, 3, 4, 5, 7] However, Mason, Hunt and Hurxythal[6] concluded there was no definite correlation but that there is a marked elevation of blood cholesterol in myxedema. In order to determine whether or not correlation existed a sample of 102 cases was investigated.

METHOD

The 102 otherwise normal persons were unselected but taken in the order in which they presented themselves for examination. There were 59 women and 43 men with an age spread of from 15 to 67 years. Basal metabolism rates were determined with the standard preparation and then on three types of commercial machines. The spread of the basal metabolic rates was from minus 38 to plus 41. All blood cholesterol determinations were fasting, obtained at the same time that the basal metabolic rate was determined. The same technicians were employed on all cases. The data obtained were treated mathematically to obtain the Pearson correlation coefficient. There were 77 persons of the entire group that had minus basal metabolic rates, but none had myxedema. These were taken as another group and the Pearson correlation coefficient obtained.

DISCUSSION

Thurstone[8] has stated "Every scientific problem can be stated most clearly if it is thought of as a search for the nature of the relation between two definitely stated variables. The correlation coefficient is a pure number, a constant which indicates the degree of relation between two variables. It varies from plus 1 to minus 1. When the relation is perfect and positive, the correlation coefficient is plus 1. When the relation is perfect but inverse, the correlation coefficient is minus 1. When there is no relation whatever between the two variables, the coefficient is zero. Other vales of the coefficient indicate intermediate degrees of relation." The correlation coefficient between the basal metabolic rates and blood cholesterol of the 102 normal persons was .079, and between the 77 persons with low basal metabolic rate was minus .072. This indicates no relation between the variables.

CONCLUSION

There is no relation between basal metabolic rate and blood cholesterol.

There is no relation between low basal metabolic rate and blood cholesterol.

* From the Medical Departments of the Ohio State University, College of Medicine and White Cross Hospital, Columbus, Ohio.

The Authors

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Psychosocial Factors in the Pathogenesis of a Peptic Ulcer in an 89-Year Old Man

CHARLES K. HOFLING, M. D.

THE initial symptom of peptic ulcer at the age of 89 years makes of a case a relative medical curiosity. Onset of peptic ulcer is most frequent during the third, fourth and fifth decades, somewhat uncommon in the seventh, and decidedly so in the ninth. Because of his advanced age with a life-long history of good health, the acute onset of symptoms following a clear-cut change in the immediate environment, and finally the verification of the nature of the lesion by direct exploration and at autopsy, the patient here presented is well suited to offer corroborative evidence for certain widely held views regarding the importance of psychological factors in the pathogenesis of peptic ulcer. One may legitimately suspect some etiological importance to lie in those circumstances immediately preceding the development of a pathological state which the random vicissitudes of nearly a century had not brought on.

CASE HISTORY

The patient, R. M., was an 89-year old white widower, a retired policeman, who came to the receiving ward of the Cincinnati General Hospital on July 27, 1947, vomiting red blood. The present illness dated back only six weeks, beginning with marked dyspepsia and anorexia. Tarry stools had been noted for about four weeks and moderate epigastric pain (coming on within 15 to 30 minutes after ingestion of food) for two weeks. Massive gastric hemorrhage with transient loss of consciousness occurred on the morning of admission.

Direct examination showed an alert, pleasant, well-preserved old man. The temperature was 99°; pulse was 80 per minute; and blood pressure was 130/80 millimeters of mercury. The physical findings were essentially normal with the following exceptions: many senile keratoses, edentia, a soft apical systolic murmur, a slightly enlarged liver, epigastric tenderness, and an enlarged prostate.

Several of the laboratory studies were contributory. The hemoglobin was 7.5 grams per 100 cubic centimeters. The red cell count was 2.2 million and the white count was 13,600 per cubic millimeter. A stool guaiac test was strongly positive. Emergency X-rays of the upper gastroenteric tract (Hampton technique) showed a large penetrating ulcer on the lesser curvature of the stomach and the absence of esophageal varices.

A tentative diagnosis of gastric carcinoma was made. Although there was no further hematemesis, the patient was operated upon on August 1, 1947. At operation the lesion was found to have the characteristics of a benign ulcer. Accordingly, only an excision of the ulcer was done. The pathologist's report, after microscopic examination of the specimen, was acute and chronic gastric ulcer with no evidence of malignant degeneration. The patient's hospital course was favorable. Because of his age and spry, friendly manner, he was a favorite with the nurses and received an unusually great amount of care and attention. Medical and surgical management was routine except for digitalization, which was instituted because of minimal postoperative signs of cardiac decompensation. Mr. M. was discharged from the hospital on August 26, 1947.

From the Department of Psychiatry, College of Medicine, University of Cincinnati, and the Cincinnati General Hospital.

The Author

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PAST HISTORY REVIEWED

A review of the patient's past history is of particular interest. Mr. M. had enjoyed exceptionally good health, having seen a physician only once in his life (for a urinary ailment) prior to the present illness. Epigastric pain, melena and hematemesis had never been noted. There had been occasional mild dyspepsia, but the patient had had, for the most part, an unusually keen appetite. Mr. M. had noted a tendency toward obesity, kept in check by the exercise his occupation required. The patient had never been a true alcoholic, but his consumption of beer and whisky had been above average. He had also been a steady smoker.

Mr. M. was the oldest of three siblings surviving infancy and had, from a rather early age, contributed to the family income by selling newspapers and doing odd jobs. His parents had both lived to old age; the father died at 87 and the mother at 76. The patient lived at home until his marriage at the age of 27. This marriage, a basically happy one, lasted 58 years, terminating with the wife's death in 1943. Immediately afterwards the patient went to live with his son and daughter-in-law, with whom he remained until the present illness.

The situation in the son's home, however, was not a satisfactory one. The patient's daughter-in-law had been at first willing to "humor" the old man, but had become steadily more and more tired of this role. There were arguments about the quality of the meals. The patient stated that his daughter-in-law made no effort to please him in this respect (as his wife had done). Six weeks before admission there had been a quarrel with a subsequent attempt to patch things up. Four weeks before admission the daughter-in-law laid down the

ultimatum that the only condition on which she would permit the patient to continue living at the house was that he would obtain his own meals, either preparing them himself or eating at a restaurant. It will be recalled that the former date corresponds with the onset of the patient's dyspepsia and anorexia, and the latter with the onset of melena.

The patient lived for one year following this first admission until August 21, 1948. He stated that he had lived alone during this year, being too proud to try to get along with the children on their terms. He prepared some of his meals and obtained the others in restaurants. During this time there were two other admissions, one on December 6, 1947, and one terminally. On both of these admissions the presenting complaints were of epigastric pain and vomiting of blood. On the December admission the patient responded well to conservative medical management. On the final admission it was found on X-ray that there was a perforation of a gastric ulcer into the lesser peritoneal sac. A jejunostomy was performed, and the usual supportive measures were taken, with care for hydration and nutrition. The patient's condition on admission, however, had been poor. He was uremic and anemic, and survived the operation by only two days. The portion of the necropsy report relevant to the patient's gastric condition noted chronic peptic ulcer with recent acute exacerbation and extensive erosion of the wall of the stomach.

DISCUSSION

Throughout most of a very long life the patient was in a singularly good position to have his dependent needs met, i. e., to have good food and drink, to be taken care of, and to be loved in a maternal way. He lived at home until 27 years of age and had the added support of having his parents live until he himself was past middle age. He found a wife who took good care of him for nearly 60 years. He, himself, made a good adjustment during this time, achieving some actual independence. Finally, so long as his son and daughter-in-law acted affectionately toward him, the patient continued to do well. It was only after meeting, for the first time in his long adult life, real frustration of dependent needs (perhaps increased by the emotional regression of extreme old age) that the patient developed his severe gastric symptoms. Thus, this patient's history tends to support the view that a frustration of dependent needs is, under certain conditions, a significant factor in the pathogenesis of peptic ulcer.

The clinical entity of myelofibrosis was first described by Heuch in Germany in 1879. This disease usually has as its early symptoms purpura, epistaxis or hematemesis. It is characterized further by slowly progressive weakness, abdominal pain, splenomegaly, bone pains, and a refractory anemia. With the anemia there are an associated thrombocytopenia, leukopenia and immature red and white cells in the peripheral blood stream—J. Kentucky State M. A.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Coroner—A contraction or corruption of the word crowner, which is the old and proper spelling of this term. It formerly designated an officer acting for the interest of the Crown in England. A coroner now is a County Officer whose duty it is to inquire into the causes of violent or sudden deaths.

Formication — A sensation resembling that caused by ants creeping or crawling on the skin. It is a descriptive term and is derived from the Latin word formica, the ant.

Coracoid—This bony process projecting from the upper margin of the neck and head of the scapula was named by Galen. In shape it has some resemblance to the bill or beak of a bird and the term is derived from the Greek work corax, a raven or crow.

Toe—This word can be traced back to the Anglo-Saxon word "tan," a shoot, and the Dutch word "teen," a twig. The toes evidently were regarded as shoots, twigs, or branches of the foot.

Deaf—This word is founded on the notion of stopping an orifice. Dead and deaf have the same primary origin, the Gothic, dauths; the Icelandic, daudr, or daufr, the Swedish, dod; and the German, todt; all meaning deprived of life, senseless, or inactive.

Leg—A descriptive term derived from the Icelandic word "leggr" meaning a stalk or stem and is comparable to the Gaelic word "lorg" meaning a staff or support.

Lisp—A word which is imitative of the sound of this speech defect. It is derived from the Anglo-Saxon word "wlispian" and is comparable to the Dutch word "lispen" and the Swedish word "laspa."

Hyoid Bone—This bone was described by Herophilus and is named for its resemblance in shape to the Greek letter Ú or upsilon. The Greek letter upsilon is aspirated as "hy" and this together with the Greek "eidios," or like, forms the word.

Egophony—This form of modified vocal resonance was described and named by Laennec. The term is peculiarly descriptive and is derived from the Greek words "aix or goat" and "phone or voice." It consists of a wavering nasal tone not unlike the bleating of a goat.

Abduct—A term descriptive of the function or action. It literally means to draw or lead away from and is derived from the Latin, ab or from, plus ducere, to lead or draw.

Androgen—The name of this male sex hormone literally means, man-maker. It is derived from the Greek words, aner, or man and genesthai, to make or be produced.

—Harry Wain, M. D., Mansfield, Ohio.

Posture—Its Role in Obstetrics and Gynecology

LEONARD B. GREENTREE, M. D.

The Author

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SO far, very little in medical literature has appeared concerning the importance of good posture in obstetrics and in gynecology. Obstetricians have begun to be aware of this importance, and so have gynecologists; but so far the most common procedure has been to turn over to orthopedic surgeons the few patients in most obvious need of help, and do little for the others. The writer submits that more stress on posture by the obstetrician-gynecologist for practically all patients will result in better health during and after pregnancy, do much to improve the individual patient's figure (an important consideration to many women in childbearing), and be of beneficial effect for many gynecological patients part of whose difficulties, at least, may be faulty posture,

Faulty posture is almost universal. It tends to be ignored because the body can compensate to an amazing extent for partial deficiency and also because many people are satisfied with second and third-degree health, having forgotten —or never having known—what first-degree health is.

Good posture is dependent on four factors:

1. A normal spinal curvature.
2. A firm foundation for the body to rest on.
3. A firm abdominal wall and pelvic floor.
4. A high diaphragm with an adequate range of excursion.

Let us consider these points in order.

EXAGGERATED SPINAL CURVES

In faulty posture, the curves of the spine become accentuated, causing the supporting musculature and ligaments to become overstretched and the intervertebral foramina to become constricted. (Figure 1-b.) The narrowed foramina may cause a mechanical irritation of the spinal nerve roots which pass through them.[1] In late pregnancy, the gravida throws her shoulders back and straightens her neck and head causing an increase in her lumbar lordotic curve. (Figure 1-c.) In a person with faulty posture at the onset of pregnancy, the superimposed pregnancy with its tendencies toward poor postural changes could conceivably cause a breakdown of hitherto strained but compensated muscles and ligaments along with a mechanical nerve root radiculitis.

Since there is a marked exaggeration of the spinal curves during the latter part of pregnancy, the gravida is advised to rest several times daily, by lying down flat on her back with a folded pillow under her knees. No pillow is placed under her head but a small one is placed under the small of her back. The bed should be firm, if not, a fracture board should be placed under the soft mattress. This position flattens the spine, and in doing so, relieves the aching back due to the exaggerated lumbar lordosis. During the puerperium, the spinal curves can be flattened by having the patient lie with her face down, and with a pillow folded lengthwise under her abdomen. This face-prone position would also tend to throw a retrodisplaced uterus forward.

FAULTS OF LOWER EXTREMITIES

A functional or correctable scoliosis may be described as a bad way of standing and is almost always due to a shortened lower extremity. This can be a readily demonstrated by placing a book under one foot of the normal subject. (Figure 2.) Scoliosis seldom causes pain in children but frequently does in adults. One can cause disappearance of a functional scoliosis by either having the patient lie down or by putting lifts on the heel of the shoe of the shortened leg. Bates[2] likens the lower extremities to the foundation of a house. If the legs are unequal, the body superstructure must be strained to maintain an upright position. Ober[3] believes that most lame backs, some of them of twenty-five years' duration, will be cured by equalizing the lengths of the lower extremities accurately. It is difficult to measure the lower extremities accurately. Carnett[4] avoids error by having the patient stand with her feet together while the examiner, seated behind the patient, compares the relative level of his own index fingers which are placed at the highest points of the patient's iliac crests. The amount of shortening is then determined by placing wooden blocks of vari-

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able measured thicknesses under the foot of the short side to bring the iliac crests to the same level.

ESSENTIAL FOOT EXAMINATION

The functional capacity of a foot depends on two factors: (a) the weight-bearing line and (b) where the foot is rigid or flaccid. A person with a good weight-bearing line has a good foot regardless of the height of the arch. A person with a faulty weight-bearing line has a poor foot regardless of the height of the arch, because the foot will be subjected to muscular strain. The weight-bearing line is determined by having the patient stand with her feet parallel and four inches apart, and then by dropping a plumb line from the center of the patella. Normally, the plumb line should fall between the first and second toes. With a poor weight-bearing line, the plumb line will fall medial to the great toe.

A flaccid foot with a poor weight-bearing line can be made into a good foot by either exercising its supinator muscles or by relieving the strain through placing a slight wedge base inwards in the heel of the shoe along with a proper arch support. A rigid foot cannot be made into a good foot, but it can be improved by either breaking up the adhesions of the tarsal joints and then by having the foot held in the supination position.[5]

A shortened Achilles tendon (heel-cord) can cause a patient considerable discomfort if she is advised to wear low-heeled shoes. Normally, the heel-cords allow the feet which are at right angles to the legs, to be bent or dorsiflexed another 15°. If a shortened heel-cord is present, the patient is either allowed to continue wearing high-heeled shoes or to take heel-cord stretching exercises.

CONTRACTED TISSUES

Contracted iliotibial bands, hamstring muscles, and anterior fascia lata along with other postural faults, trauma and diseased conditions are the common causes of low backache. Contracted iliotibial bands and hamstring muscles limit straight leg flexion at the thigh and prevent the patient from touching her toes with her fingers when her knees are extended. The iliotibial band is seen as a taut tendon on the lateral side of the thigh, and is readily demonstrated by Ober's test. Contracted anterior fascia lata limits flexion of the knee. Stretch-



Fig. 1a. Normal Posture



Fig. 1b. Faulty Posture



Fig. 1c. Normal Late Pregnancy



Fig. 2 Functional Scoliosis Due to Elongation of Right Lower Extremity by a Book

ing exercises are of real value in relieving the symptoms due to these contracted tissues.

FASCIAL OVERSTRETCHING

Normally, the abdominal musculature has enough tone to allow only a light relaxation of the anterior abdominal wall. The circumference of the nulliparous abdomen at the level of the xiphoid should normally be greater than that taken at the level of the umbilicus. The pendulous abdomen which appears following parturition and the increased waistline of the "middle-age spread" is due chiefly to the relaxation of the fascial layers enclosing the atonic abdominal wall musculature. Since this overstretched fascia contains little or no elastic fibrils, it will not regain its original shape readily even though the muscle tone is improved later on.

Prevention of fascial overstretching rather than treatment for it should be the goal in dealing with the problem of a pendulous abdomen, since most attempts to correct a relaxed abdominal wall in pregnancy are liable to result in failure. The use of a maternity corset allows the gravida with a pendulous abdomen to have temporary good body mechanics, though her abdominal muscles and fasical support may be gravely at fault. However, in the absence of a pendulous abdomen, the use of a maternity corset in normal obstetrics should be discouraged, since its use tends to cause a loss of abdominal muscle tone along with a resultant fascial weakness.

CORRECTIVE EXERCISES

The large gluteal and abdominal wall muscles are the chief supporting muscles of the back. As soon as the pain of an acutely lame back disappears with rest on a firm bed, Ober[3] prescribes gluteal and abdominal wall exercises to improve the tone of these muscles.

1. **Glutei Maximi Exercise:** Squeeze the buttocks together as if holding a coin between them, and then relax them. Gradually increase until the exercise is done at least fifty times, twice daily.

2. Progressive-resistance exercises are the most effective forms of exercise to increase the strength and work capacity of both normal and atrophic muscles.[6] These exercises can double the power of normal muscle within four to six weeks.

Progressive-Resistance Abdominal Wall Exercise: The patient lies flat on her back with her toes hooked under a couch or bed bar, or with someone holding her legs down below the knees. With her hands placed behind her neck or head, she raises herself to the sitting position. This is repeated ten times at least twice daily.

3. Douthwaite[7] has shown how voluntary muscles can be contracted and relaxed at will without causing gross body movements. These static muscular contractions are invisible to onlookers, and can thus be practiced in public places.

Invisible Abdominal Wall Exercise: While pressing her buttocks together, the patient pushes the muscle over her "stomach" in and out at least fifty times, twice daily.

Invisible Pelvic Floor Exercise: The levator ani muscles are exercised by alternately drawing up and relaxing her anus at least fifty times, twice daily. These exercises can be done while she is standing, sitting, or lying down.

The diaphragm plays an important role in normal body mechanics. Not only is it the chief respiratory muscle; it is also an important pump in the transport of venous blood back to the right heart. Thus faulty diaphragmatic action can cause a venous stasis along with an increased predisposition to phlebothrombosis and varicosities. Anatomically, a low-lying diaphragm can also interfere with the normal function of both the thoracic and abdominal viscera by:

1. Dragging on its attachments to the pericardium, stomach, and liver, and
2. Direct encroachment on the autonomic coeliac plexus which to a large extent controls the activities of the abdominal viscera.

Diaphragmatic Breathing Exercises are demonstrated to the patient, in view of the importance of the diaphragm in normal body mechanics. She is instructed to rebreathe whereby each expiration is slightly less than the inspiration, so that by the end of the fifth inspiration, the chest cage is expanded and held highly. Expiration is then accomplished by an upward, inward pull of the lower abdominal muscles.

SUMMARY

Applying the principles of normal body mechanics can be a useful adjunct to other measures employed in obstetrics and gynecology. Good posture often notably improves the health and figure of the patient. This paper has attempted to show:

1. The standards of normal posture.
2. Methods of making postural examinations.
3. The importance of an orthopedic consultation when unusual postural defects are present.
4. Procedures whereby good posture is maintained and faulty posture is improved.

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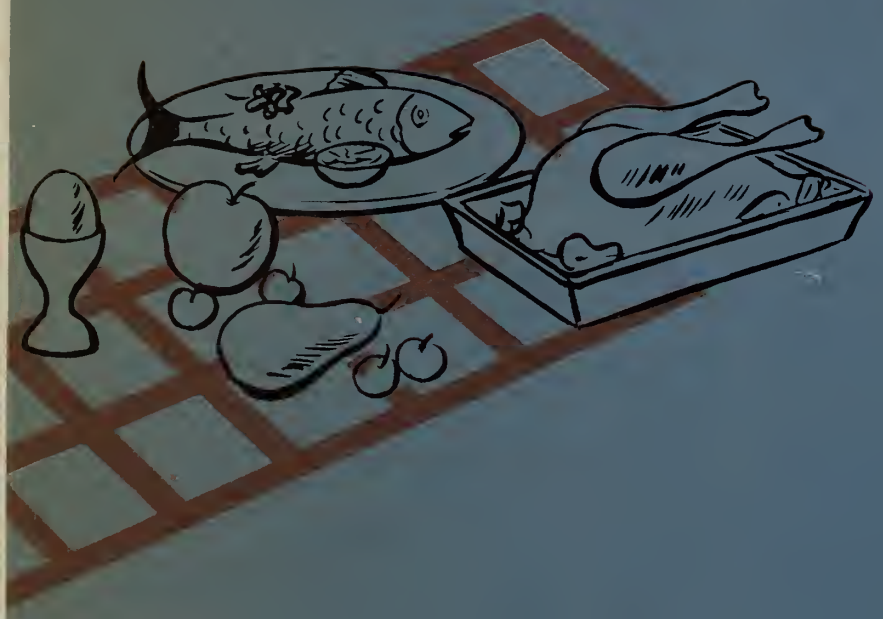
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Aneurysm of Left Common Iliac Artery Producing Thrombosis of Spermatic Artery and Vein With a Review of the Literature

PAUL J. SHANK, M. D.

THIS is the history of a (male) farmer 70 years of age who had always enjoyed good health until his present illness. While butchering, he lifted a side of beef and was seized with a pain in his left testicle. Approximately one hour later, while eating his noon meal he became nauseated, vomited and the pain became more intense. His family physician was called and diagnosed the case as a strangulated left inguinal hernia. He gave him ¼ grain of morphine sulfate and advised him to be admitted to the hospital. The patient refused this advice and remained quiet for most of the afternoon. At about 6:00 p. m. the pain returned and the family physician was called and gave him again ¼ grain of morphine sulfate and sent him to the hospital.

The patient was examined by the author at approximately 9:00 p. m. and found him in a state of mild shock. The examination was essentially negative, except for the abdomen. In the left inguinal canal and scrotum there was a firm tender mass which could not be reduced into the abdomen. The blood count on admission was white blood cells: 20,700, 87 per cent polymorphonuclears, 15 per cent of which were stabs, 11 lymphocytes and 2 eosinophils. The urinalysis was essentially negative except for a trace of albumin and 10 white cells per high power field. A diagnosis of left strangulated inguinal hernia was made and operation was advised.

OPERATION

The patient was given 1000 cubic centimeters of 5 per cent glucose in distilled water before being taken to the operating room. Local anesthesia of 1 per cent novocaine® was used to infiltrate the tissues. A left inguinal skin incision was made and carried down through the subcutaneous fat. It was noted that tissues were quite edematous. Upon incising the fascia the entire spermatic cord with its vein and artery were very hemorrhagic and thrombosed. Thorough exploration of the cord revealed no sac. The peritoneum was opened at the internal abdominal ring. The examining finger was inserted and a pulsating aneurysm was palpated. Due to the complete thrombosis of the spermatic vessels it was decided to completely remove the testicle, cord and its contents. This was done. The true condition could not be determined at this time. The internal abdominal ring was closed, the fascia and skin was closed in layers. He withstood the operation fairly well considering his state of shock. His blood pressure never rose above 90 and on several occasions dropped down as low as 70. The following day the white blood cell count dropped to 14,240, the red cell count was 4,090,000 with 82 per cent polymorphonuclear, 15 of which were stabs and 18 lymphocytes. The Wassermann and Kahn tests were taken the first postoperative morning, and were negative.

The postoperative convalescence was quite stormy and was progressively a downhill course. He received daily intravenous infusions of 5 per cent glucose, amigen® and blood. However, in spite of all this treatment he did not react. The blood pressure constantly remained around 90/70. On the fifth postoperative day the hemoglobin was 60 per cent, red cell count was 3,410,000, white cell count was 14,300 with a differential count of 84 per cent polymorphonuclear leukocytes, 35 of which were non-filamented cells and 16 lymphocytes. He had had two transfusions up until this time, but it was apparent there was red cell destruction in view of the anemia that was present. He died on the 8th day.

POSTMORTEM OBSERVATIONS

A postmortem examination was made, the results of which are as follows: "Body is that of a fairly well nourished seventy-year old white male. Chest: There are many bilateral pleural adhesions with areas of consolidation, heart musculature firm, no valvular abnormalities, coronaries are smooth. The aorta: There is an aneurysm about the size of an orange found in the left common iliac artery about a half-inch below the bifurcation of the abdominal aorta. The aneurysm has ruptured on the lateral surface. The abdomen: the entire left abdominal cavity contains a large retroperitoneal organized blood clot. The aorta and common iliacs are quite arteriosclerotic. The diagnosis: A ruptured aneurysm of the left common iliac artery."

LITERATURE REVIEWED

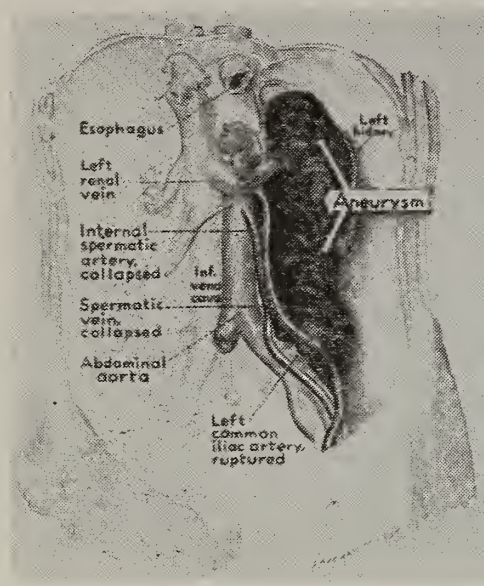
The literature is abundantly filled with cases of aneurysm of various areas of the body, but surprisingly scant in respect to aneurysm of the common iliac artery. One paper deals with the bilateral involvement, another with obstruction to delivery, while a third by Zimmerman[1]

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which simulated a perinephritic abscess. Holcombe[1] collected a series of 172 aneurysms over a period of ten years and of these only two were confined to the common iliac. Crisp[2] found eleven common iliac aneurysms out of 552 cases of aneurysms. He stated that the order of frequency in the iliac group is, ilio-femoral 1,



ANEURYSM of left common iliac artery producing thrombosis of spermatic artery and vein.

femoral 2, external iliac 3, **common iliac 4**, internal iliac 5. Lucke[3] and Rea[3] in an analysis of 12,000 of their own, and 160,145 collected autopsies, found aneurysms in 1452; or one in every 111 patients examined postmortem—an incidence of 0.9 per cent. Garland[4] in his 12,000 postmortems found the incidence of aneurysms to be 2.2 per cent. In Garland[4] and Lucke and Rea's[3] series syphilis was the most frequent cause, the abdominal aorta, thoracic aorta and splenic artery. Highest incidence of aneurysms was between 36 and 40 years. Garland[4] in his 12,000 consecutive autopsies found 167 cases of aneurysms. The most frequent site of aneurysm was in the aorta. He states that aneurysms of the large arteries of the extremities are uncommon. In all of these series syphilis played an important part in the production of the aneurysm, being the etiological factor in from 20 to 100 per cent. Arteriosclerosis was also rather frequent. Both Lucke[3] and Garland[4] stated that bacterial infections can cause aneurysm, usually of the mycotic type.

MYCOTIC ANEURYSMS

Aneurysms developing during the course of bacterial endocarditis and some of the acute infectious diseases with concomitant bacteremia form a distinct clinical group and are known as mycotic aneurysms. Blakemore[5] in a recent article described 32 cases of aneurysms of the abdominal aorta admitted to the Presbyterian Hospital and states that arteriosclerosis was the cause of the aneurysm in 26 of these cases. These aneurysms were fully developed, fusiform in shape and arose from the abdominal aorta, three or more centimeters distal to the origin of the renal arteries. Syphilis was the etiological agent in six of the 32 cases, these aneurysms being sacular and causing vertebral bony erosions in four instances. From the latter group the aneurysms arose distal to the renal arteries in only one of the six cases. There were only two females in the entire group of 32 cases having arteriosclerotic aneurysm. The average age of those with arteriosclerotic aneurysm was 60 years, while it was 42 years for the syphilitic group. Aside from the fact that the arteriosclerotic aneurysm is usually fusiform, it seems likely that there may be another factor accounting in part for the bony erosion; namely, enlongation of the abdominal aorta. The popliteal artery and the lower abdominal aorta are the common arteries affected by the arteriosclerotic aneurysm. So it is readily seen that aneurysm of the common iliac artery is a rarity.

Now let us discuss the still rarer condition of a thrombosis of the spermatic vessels being produced by pressure from the aneurysm. The author in an extensive review of the literature has been unable to find any case in which there is aneurysm of the left common iliac artery which has produced a thrombosis of the spermatic vessels by pressure or from any cause. Rives[6] from the Mayo Clinic reports a case of ureteral obstruction caused by aneurysm of the iliac artery. He reports that the autopsy revealed an arteriosclerotic aneurysm of the right common iliac artery which had ruptured and caused partial obstruction on the right ureter, a hydronephrosis grade II and a beginning pyonephrosis. The ureter was compressed between the right common iliac artery and the aneurysm at the point of crossing the artery. (See figure.) In the author's case, the spermatic vessels were compressed against the vertebral bodies and abdominal aorta to the medial side, with the aneurysm exerting its force from the lateral side. This was found to be the true condition at postmortem examination.

CONCLUSIONS

A rare and unusual case of an aneurysm of the left common iliac artery producing pressure against the spermatic vessels with a resultant thrombosis of those vessels is presented. A short review of the literature is given.

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Solitary Nonparasitic Cyst of the Liver

H. H. PEVAROFF, M. D.

THE incidence of solitary nonparasitic cyst of the liver is sufficiently rare to warrant the report of this case. Up to the year of 1948 there were 192 cases in the literature. These reported cases include all ages but the cysts are most commonly found between the ages of 40 and 50. As stated by Montgomery there have been only 27 cases under the age of thirteen years.

CASE REPORT

F. S., female, age 51, was admitted to the Mount Sinai Hospital of Cleveland, Ohio, on December 18, 1948. She had a long history of about five years of indigestion, nausea and pain in the right upper quadrant radiating to the back and shoulder. Physical examination revealed an obese woman not acutely ill. There was moderate tenderness in the right upper quadrant but there were no palpable masses. Blood and urine studies were normal. Cholecystogram revealed the presence of one large calculus in an otherwise normally functioning gall bladder. Barium studies of the stomach and duodenum were normal. The preoperative diagnosis was chronic cholecystitis with cholelithiasis.

Operation: On December 20, 1948, under general anesthesia the abdomen was opened through an upper right transverse incision. A large, smooth-walled bluish-colored cystic mass immediately presented itself. This mass measured approximately 7½ centimeters in diameter and was situated in the antero-inferior portion of the right lobe of the liver, immediately under the gall bladder to which it was lightly attached. The gall bladder was large, thickened and elongated and contained the large calculus which was described in the X-ray. To make sure that the cyst was not part of the biliary duct system, the gall bladder, the cystic duct, the common and hepatic ducts were completely dissected free. It was then possible to remove the gall bladder, with certainty that the cyst was extra biliary in location. A line of cleavage was readily found between the cyst wall and the liver, and by means of careful sharp and blunt dissection the cyst was enucleated from the liver substance. A small amount of venous bleeding was readily controlled with oxycel packing. Thorough examination of the kidney, pancreas and liver revealed no further cysts. The abdomen was then closed leaving a single Penrose drain in the liver bed.

Pathologic Examination—Gross: Specimen removed reveals a thin-walled translucent cyst measuring 7½ centimeters in diameter. The contents are clear mucoid material. The outer covering of the cyst is moderately hemorrhagic whereas the inner lining is smooth, glistening and bluish-pink in color.

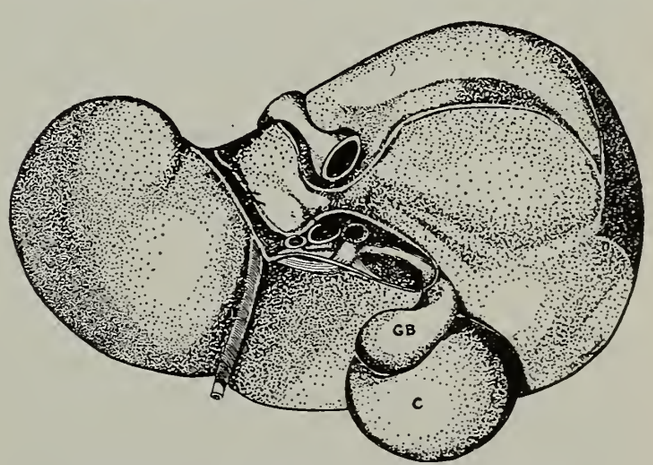
Microscopic: Section of the cyst wall shows a layer of collagenous fibrous tissue containing a few small blood vessels. The inner lining varies from cuboidal epithelium to squamous cell type. The outer wall has attached bits of parenchymal cells and bile ducts.

Pathologic Diagnosis: Cyst of liver, 7½ centimeters in diameter (Bile duct retention type).

Postoperative and Subsequent Course: There was a moderate febrile reaction with temperatures up to 101 F for 5 days with gradual return to normal. Bile drainage was profuse for 8 days following which the drainage gradually subsided. The Penrose drain was removed on the 10th postoperative day and the wound healed rapidly. The patient was discharged as cured on her 12th postoperative day and has remained well.

DISCUSSION

Nonparasitic cysts of the liver may be single or multiple. Multiple cysts more commonly are associated with cysts of the kidneys, pancreas, spleen, lungs and brain. Solitary nonparasitic cysts are more common in adults. They seem to occur more often in females than in males; the ratio being 4 to 1. Solitary cysts are more commonly found at the antero-inferior portion of the right lobe of the liver. Their size varies and symptoms are usually not produced unless there is encroachment upon adjacent organs. The external surface of the cysts is usually smooth, glistening and greyish-blue. The thick-



INFERIOR SURFACE OF THE LIVER
WITH A SOLITARY CYST IN THE RIGHT LOBE

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From the Dept. of Surgery of the Mount Sinai Hospital, Cleveland, Ohio.

ness of the cystic wall is variable; the contents vary from clear watery to sometimes yellowish-brown fluid and may show albumin, mucin, cholesterol, blood and rarely bile. The correct preoperative diagnosis is rarely made. Treatment of solitary cysts is surgical extirpation where conditions permit. Where the cyst is too large to permit complete excision, marsupialization with drainage is recommended. It is generally agreed that these cysts are derived from congenital malformations.

SUMMARY

A case of solitary nonparasitic cyst of the liver in a 51-year old woman is presented. The cyst was completely removed with complete recovery.

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APHORISMS, ADAGES AND MAXIMS

"Remember to forget."

"It is easier to worry our heads off than to laugh ourselves to death."

"Malnourished lawyers and malpractice suits are closely related."

"Some people when they die will have to climb up to get into hell."

"It takes as much grace to make a saint of a Republican as it does to make a saint of a Democrat."

"We do not break down mentally from overwork but rather from overworry."

"Why spend health to get wealth and then spend wealth to get health?"

"What will make a well person sick will make a sick person sicker."

"The rich and the poor reach the same level in the cemetery."

"The more patients a physician has the more patience he needs."

"Never spend money for things you don't need just to please people you don't like."

"Tombstones, like books, are made by the living for the living."

"Better live in the basement of heaven than in the cupola of hell."

"Natural forces within us are the true healers of disease."

"Reputation is what you have when here, character is what you have when you go away."

—Submitted August 15, 1950,
John J. Sutter, M. D., Lima, Ohio.

The Efficiency of Local Anaesthetics When Used In Small Doses

The anaesthetic index, a ratio of relative potency to relative systemic toxicity, was introduced by McIntyre and Sievers in 1937 and is especially applicable in situations where large quantities of anaesthetic are introduced into the body. In ophthalmology where small amounts are used, the important factors are tissue toxicity and the concentration necessary to produce anaesthesia of a given duration (E. C. 50).

No accurate method has been developed for assessing toxicity of local anaesthetics applied to the eye. The skin reactions to intradermal injections of various concentrations would suggest the toxicity that might be exerted on the cornea. A series of intradermal injections was carried out on guinea pigs and the average diameter for each reaction measured in 24 hours. Diameter was plotted against log concentration and a graph obtained from which relative toxicity was ready directly.

The E. C. was estimated by topical application to guinea pigs' eyes. Equal amounts of different percentage strengths of various anaesthetics were instilled into the eyes for a definite period of time and the blink reflex tested until complete return. Plotting duration of anaesthesia against log concentration resulted in a graph of parallel lines from which relative potency values were readily obtained.

A series of experiments was carried on to determine the E. C. 50 by retrobulbar injection in guinea pigs. Corneal sensitivity was used as the criterion of duration of block. By plotting the latter against log concentration a relative relationship was obtained.

With the above data available a relative rating index for all the anaesthetics can be calculated for both surface anaesthetic effects and nerve block according to the following formulae:

Relative rating for unknown compared to cocaine:

$$\frac{\text{E. C. 50 cocaine}}{\text{E. C. 50 unknown}} \quad \frac{\text{Tissue toxicity of unknown}}{\text{Tissue toxicity of cocaine}}$$

Relative rating for unknown compared to procaine:

$$\frac{\text{E. C. 50 procaine}}{\text{E. C. 50 unknown}} \quad \frac{\text{Tissue toxicity of unknown}}{\text{Tissue toxicity of procaine}}$$

—H. S. Hamilton, M. D.,
J. F. Aikenhead, M. D.,
Toronto, Canada.

Brief authors' abstract of paper presented at charter session of the Association for Research in Ophthalmology, East-Central Section, held in Cleveland, Jan. 10, 1950.

Control of Diabetes: Glycosuria an Unreliable Index to Glycemia

HENRY J. JOHN, M. D.

ONE of the commonest fallacies in medical practice is the belief that the presence or absence of glycosuria may be used as a reliable guide for regulating the dosage of insulin, in the treatment of a diabetic patient. This is a point which I have stressed repeatedly, and it has also been brought out by other authors. Despite the ample proof that glycosuria and hyperglycemia may or may not exist simultaneously, the error of accepting glycosuria as proof of hyperglycemia persists, both in teaching and practice. From the standpoint of the facility of technic, it would be desirable if glycosuria were a direct index of the blood sugar level, since the urine test is so much simpler to perform than a blood sugar determination. Unfortunately, however, the fact remains that the level of sugar in the urine may be entirely misleading in appraising the state of sugar metabolism in a patient who has an abnormally high or low renal threshold for sugar. For this reason, periodic examinations of the blood sugar are essential in the control of diabetes in the individual case.

This opinion is based on a study of thousands of diabetics, during a twenty-six-year period, subjected to simultaneous tests of the urine and blood sugar. This clinical experience has shown that a patient treated with a fixed insulin dosage based on periodic blood-sugar determinations (barring accident or some gross dietary indiscretion) is under far better control of the diabetic condition than one who changes his insulin dosage daily according to the results of his own urine tests. The dangers of overdosage of insulin, as a result of this practice, cannot be minimized.

Perhaps the best way to demonstrate the importance of recognizing the frequent disparity in renal and blood sugars is to show the data in actual clinical cases. Figure 1 shows information as to the renal and blood sugars in fifteen patients I saw recently during a two-month period. These were all patients who had been under treatment by other physicians who had attempted to control the diabetes by regulation of insulin dosage according to several urine tests a day. The figure shows clearly that often there was little relationship between glycosuria or aglycosuria and the blood sugar level at the time the urine tests were made.

Submitted May 2, 1950.

The Author

● Dr. John, Cleveland, Ohio, is a graduate of Western Reserve University School of Medicine, Cleveland, 1916; fellow, American College of Physicians; member, American Diabetes Association; and visiting physician, University, St. Luke's and Huron Road Hospitals.

A brief review of the salient features in these cases is presented, to demonstrate the clinical importance of the use of proper laboratory study in the management of diabetes.

Case 1. A woman, aged 23 years, has normal blood sugars morning, noon and evening, when taking 60 units of protamine zinc insulin and 6 units of regular insulin. Although there is no hyperglycemia with this insulin dosage, glycosuria is present throughout the day, and is heaviest at noon.

If this patient were attempting to follow the usual routine on the basis of urine sugar examinations, she would be directed to take 6 to 10 units of insulin in addition to the amount taken in the morning, and this would very likely cause an insulin reaction in the afternoon. In this case, it is quite obvious that extra insulin is not indicated at noon, despite the finding of heavy glycosuria.

Case 2. A man, aged 56, when taking 20 units of protamine zinc insulin, shows elevation of the blood sugar morning, noon and evening, even though there is no glycosuria at any time. In this case, just the opposite of Case 1, if the finding of glycosuria were used as an index for regulation of insulin dosage, this man would be advised not to take more insulin, when this is obviously needed.

Case 3. A girl, aged 12 years, who is taking 30 units of protamine zinc insulin and 30 units of insulin, displays normal blood sugar in the morning and at noon, but the evening level is dangerously low,—28 milligrams per 100 cubic centimeters. There is no sugar in the urine in the morning, but glycosuria is heavy at noon. According to traditional practice, this would mean that she should receive extra insulin at noon, which would have been really dangerous, perhaps, in reducing the blood sugar. What she actually needs, instead of extra insulin, is a reduction in the insulin dosage.

Case 4. A girl, aged 13½ years, receiving 26 units of protamine zinc insulin and 28 units of insulin each morning, shows slight elevation of the blood sugar in the morning, but at noon and in the evening, the level is normal. Glycosuria is present throughout the day, and is heaviest at noon, but there is no

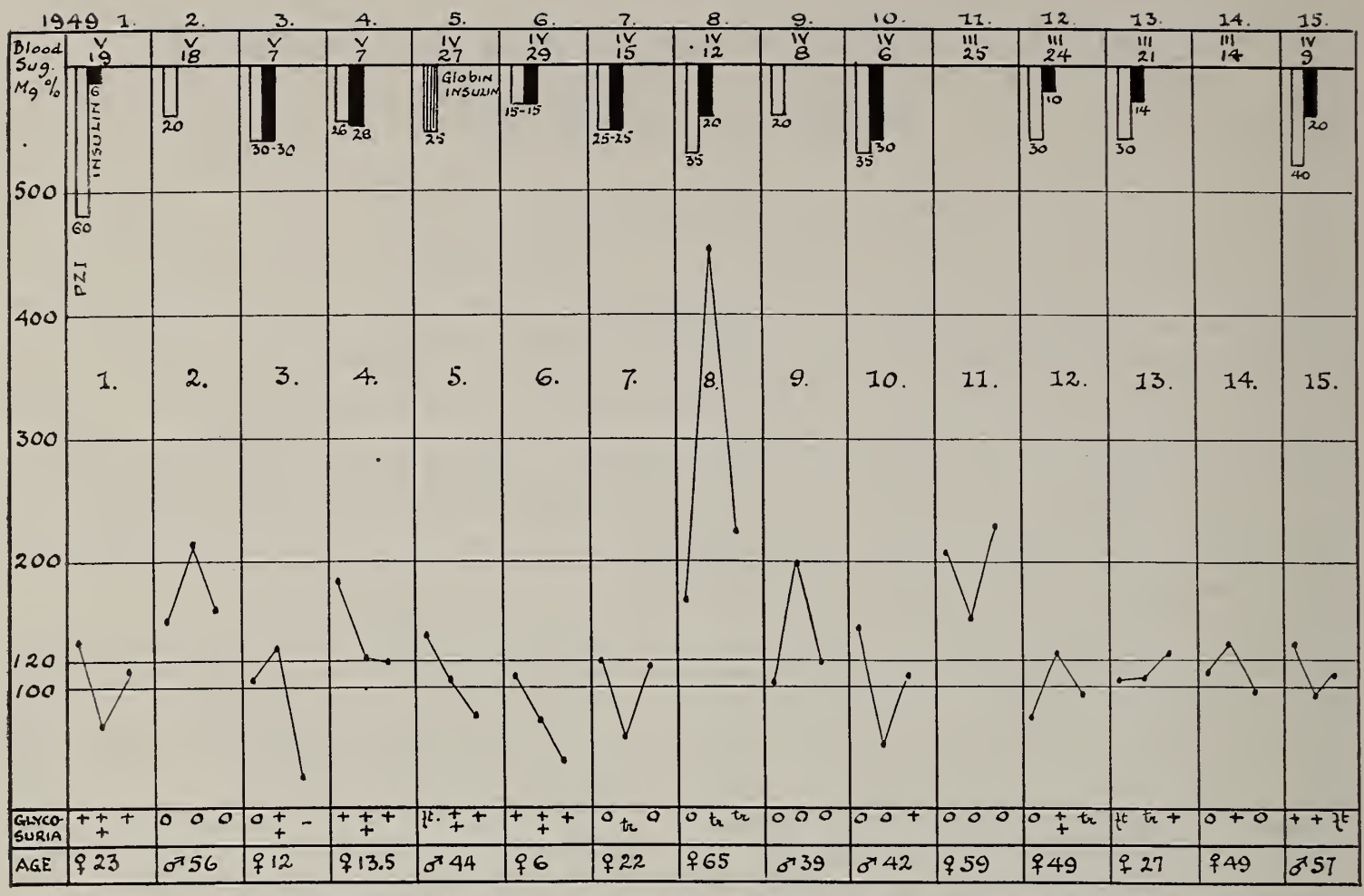


Fig. 1. Blood sugar and urine sugar determinations made three times a day on 15 different diabetic patients, to show that glycosuria is not a safe or reliable guide to the status of sugar utilization.

indication that additional insulin should be given before lunch in this case.

Case 5. A man, aged 44, who is taking 25 units of globin insulin each morning, has normal blood sugar throughout the day, yet glycosuria is present at each determination and is heaviest at noon. Here, as in Case 4, there is no indication for giving additional insulin at noon, which would be done if glycosuria were being used as the guide.

Case 6. A little girl, aged 6 years, receiving 15 units of protamine zinc insulin and 15 units of insulin, has normal blood sugar in the morning and at noon, but the evening blood sugar is quite low, i. e., 40 milligrams per 100 cubic centimeters. As in the preceding cases, glycosuria is present throughout the day and is heaviest at noon. If extra insulin were to be given at noon, because of the glycosuria, no doubt an insulin reaction would be precipitated.

Case 7. A young woman, aged 22 years, has normal blood sugar on an insulin dosage of 25 units of protamine zinc insulin and 25 units of regular insulin. The urine is free of sugar in the morning and evening, but a trace is present at noon. This is entirely without significance, in view of the normal blood sugar.

Case 8. A woman, aged 65 years, with an insulin dosage of 35 units of protamine zinc insulin and 20 units of insulin, displays pronounced hyperglycemia throughout the day. However, the urine shows only a trace of sugar at noon and in the evening, and the morning specimen is normal. With traditional management, her insulin dosage would not be increased, but this is definitely needed, in view of the blood sugar levels.

Case 9. A man, aged 39 years, taking 20 units of protamine zinc insulin, has normal blood sugar in the morning and evening, but at noon, the sugar level is 200 milligrams per 100 cubic centimeters. There is no glycosuria at any time. If urine examination were to be used as a guide, there would be no change in the insulin dosage in this case, whereas 4 to 6 units of insulin should be added to the protamine zinc insulin in the morning to take care of the elevation of blood sugar occurring at noon.

Case 10. A man, aged 42 years, who is taking 35 units of protamine zinc insulin and 30 units of insulin, has blood sugar levels of 146, 52 and 108 milligrams per 100 cubic centimeters, The urine is sugar-free in the morning and at noon, but there is mild glycosuria in the evening. To correct the elevation of the blood sugar in the morning, a change to 40 units of protamine zinc and 25 units of regular insulin is required. This would bring down the blood sugar in the morning and increase it slightly at noon. The finding of glycosuria in the evening presents no indication for additional insulin at that time of day, for that would simply upset a fairly well controlled situation.

Case 11. A woman, aged 59 years, is taking no insulin, but displays considerable hyperglycemia throughout the day. There is no sugar in the urine at any time, and hence urine examination alone certainly would not indicate that she requires a small dose of protamine zinc insulin to control the situation properly.

Case 12. A woman, aged 49 years, who is taking 30 units of protamine zinc insulin and 10 units of insulin, has a normal blood sugar all three times during the day, and yet the urine contains an excessive amount of sugar at noon and a trace in the evening. Control of the diabetes would be drastically upset if she were

to receive extra insulin at noon on the basis of the urine examination.

Case 13. A woman, aged 27 years, has a normal blood sugar throughout the day with a dosage of 30 units of protamine zinc insulin and 14 units of insulin. The urine shows a faint trace of sugar in the morning, a trace at noon, and 1 plus in the evening. Here again, extra insulin in the evening would upset an ideal state of control.

Case 14. A woman, aged 49 years, has a normal blood sugar without taking insulin. However, there is a faint trace of sugar in the urine morning and evening and considerably more at noon. Insulin is contraindicated, despite the glycosuria, since the blood sugar remains at at a satisfactory level without it.

Case 15. A man, aged 57 years, receiving 40 units of protamine zinc insulin and 20 units of insulin, has normal blood sugar three times a day. Yet glycosuria of some degree is present in all three determinations. This is another instance in which glycosuria furnishes a false indication of the need for insulin.

Overinsulinization. When glycosuria is used as the sole guide in regulating the dosage of insulin, it frequently happens that the glycosuria persists, even when the insulin dosage is considerably increased. Some patients are sensitive to insulin and have an insulin reaction under such circumstances; others do not. Some patients have an insulin reaction with merely a mild hypoglycemia and others may tolerate a blood sugar level as low as 30 milligrams per 100 cubic centimeters without displaying a reaction. The two cases illustrated in figure 2 show the enormous doses of insulin that are sometimes given in the futile and erroneous attempt to control glycosuria.

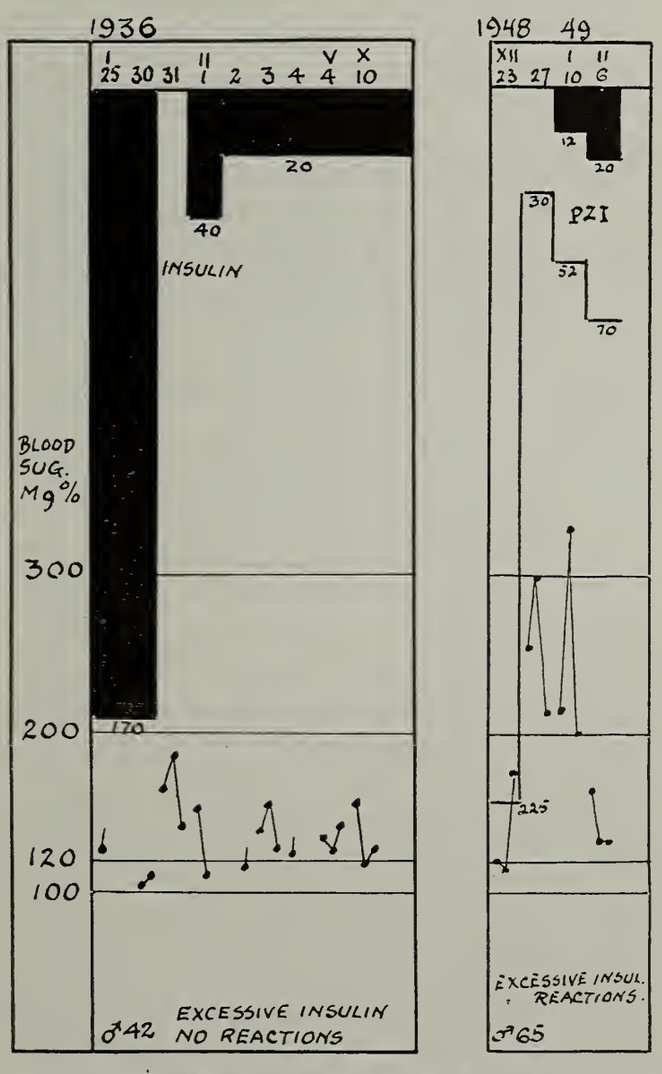


Fig. 2. Studies in two cases of diabetes in which insulin dosage had been excessive, because of the presence of glycosuria.

The first patient, a lawyer, aged 42 years, was taking 170 units of insulin a day, when I first saw him in 1936, because of a heavy glycosuria. No insulin reactions occurred with this dosage. The day after I first examined him, I studied the blood sugar throughout the day without any insulin at all, and this was only moderately elevated. The following day, he received 40 units of insulin, and after that, only 20 units. This amount was sufficient to control the blood sugar adequately. Hence, although the excessive intake of insulin produced no serious reactions, it was an enormous waste, since more than eight times the amount needed for control of the diabetes was being used .

The second patient, also a lawyer, aged 65 years, was taking 225 units of protamine zinc insulin in two daily doses when I first saw him in December, 1948. He was having frequent insulin reactions which interfered with his work, but he thought these were unavoidable, just part of a diabetic's sorry lot. Since he continued to show glycosuria, his physician would not let him decrease the insulin dosage. During the next month, his insulin requirement was found to be 70 units (protamine zinc insulin, 50 units, and regular insulin, 20 units). Several examinations were required to establish adequate control. At first I prescribed 30 units of protamine zinc insulin, but the blood sugar levels remained slightly evelated, so the dosage was increased to 40 units of protamine zinc insulin and 12 units of insulin. The result was still not quite satisfactory, so the dosage was increased to the 70-unit figure, on which control has remained entirely satisfactory. This dosage of 70 units is considerably different, both in cost and comfort to the patient, from 225 units he was taking on the basis of urine examinations.

COMMENT

Despite the irrefutable evidence presented by cases such as those cited here, which are seen so frequently in a diabetic practice, it still remains an almost universal custom to adjust the dosage of insulin on the basis of glycosuria and to administer extra insulin when glycosuria is found. This is often a faulty procedure which results from entirely faulty reasoning, for it leaves out of account all consideration of individual differences in the renal threshold for sugar. If the threshold is low, the patient shows heavy glycosuria most of the time, even when the blood sugar is low. If his threshold is high, no sugar will show in the urine, even in the presence of a very high blood sugar level. To give additional insulin in the former instance and to withhold it in the latter, on the basis of the urine examinations, is to fail to control the diabetic state adequately. Excessive insulin dosage does not always produce severe insulin reactions, but even when it does not,

it is a source of inconvenience, discomfort and needless expense to the patient.

The cases presented here should make it abundantly clear that the proper evaluation of the sugar utilization can be made only by determinations of the blood sugar level three times a day, before meals. Even in the normal person, there is some elevation of the blood sugar after meals, but the important thing to determine is whether the blood stream is free of excessive sugar before the next meal. When it is, the control of the diabetic condition is satisfactory, no matter how large or how small the insulin dose, and regardless of the presence or absence of sugar in the urine.

SUMMARY

The important fact, so generally overlooked, that glycosuria is **not** a reliable guide for the regulation of insulin dosage in the management of diabetic patients, is explained and illustrated by fifteen cases in which glycosuria was present with normal blood sugar levels; or no sugar was found in the urine of patients whose blood sugar level at some time during the day was elevated abnormally. Two additional cases are described in which enormous doses of insulin were actually being prescribed to patients by other physicians in a futile attempt to control the ever-present glycosuria. In one of these, glycosuria remained, despite the fact that the patient was taking more than eight times the amount of insulin required to keep his blood sugar normal throughout the day. Sometimes this excessive insulin intake produces insulin reactions and sometimes not, depending on the individual susceptibility of the patient to insulin.

The important procedure to use in regulating the control of diabetes is the blood sugar determination, three times a day, before meals. If the blood stream clears itself of excessive sugar by the time of the next meal, then all is well, whether or not glycosuria is present. If some excess of sugar remains in the blood stream just before the following meal, then additional insulin is indicated, again regardless of the urine tests. If the blood sugar is elevated in the morning, then the protamine zinc insulin needs to be increased. If the level is normal in the morning, but increased at noon, then the dose of regular insulin needs to be increased. The purpose of all diabetic treatment is to achieve as nearly as possible a normal, physiologic level of blood sugar at all times during the day.

It is suggested that too frequently the diagnosis of fungus infection of the hands is made when a nummular eczema exists. A greater percentage of these eruptions is due to allergic responses, most of which are dietary.—Burton F. Barney, M. D., J. Florida M. A., 37:212, 1950.

The Liquid Therapeutic Diet

The therapeutic diet in which all solid foods are eliminated will be found useful in the field of general practice, in general surgery, and also in the field of oral surgery . . . This list may be briefly altered as the doctor sees fit.

Feeding Time	*Feeding*
6 A. M.	Beat together 6 ounces orange juice, 1 egg, 1 tablespoon Karo syrup.
8 A. M.	6 ounces milk, 4 ounces light cream, 1 tablespoon dried skim milk, mixed.
10 A. M.	Cereal gruel, made with 1 cup milk, 1 tablespoon of oatmeal, Pablum or enriched cream of wheat, 1 tablespoon dried skim milk, thoroughly cooked and strained with 1 tablespoon of sugar added.
12 Noon	Creamed soup, made with 5 ounces of light cream, 1 tablespoon dried skim milk, 3 ounces of strained vegetables (the 3 to 4 ounce prepared cans or jars of strained baby vegetables or meats may be used), 1 can or jar to a serving.
2 P. M.	Beat together 6 ounces orange juice, 1 egg, 1 tablespoon Karo syrup.
4 P. M.	Creamed soup, made with 5 ounces of light cream, 1 tablespoon dried skim milk, 3 ounces of strained vegetables (the 3 to 4 ounce prepared cans or jars of strained baby vegetables or meats may be used), 1 can or jar to a serving.
6 P. M.	8 ounces of tomato or orange juice.
8 P. M.	Beat together 6 ounces milk, 1 egg, remainder of the 4 ounces of dried skim milk, 1 tablespoon sugar. (Take vitamin preparation with this feeding.)

NOTE: The 6 A. M. and 8 A. M. feedings may both be taken at 8 A. M. for convenience if desired. It is necessary to be fed more often on a liquid diet. Three feedings a day are not enough. The patient feels overfed or hungry unless fed every two hours. If the patient is working, several feedings may be mixed together and placed in thermos bottles and taken to work. Salt feedings to taste. Malt, vanilla and other flavors may be used. It is not necessary to add the dried skim milk as recommended above; it may be added in greater amounts to any feeding as long as 4 ounces a day is consumed. The amount of dried skim milk may be increased or decreased as the doctor sees fit.—C. J. Speas, D. D. S., J. Tenn. State M. A., 43:325, 1950.

Pericarditis Complicating Pregnancy: Case Report

DAVID H. GREEGOR, M. D.

REPORTS on acute pericarditis with effusion during pregnancy are found rather infrequently in medical literature. Hence, we are reporting this case which may serve as a reference aid to others encountering the same problem.

CASE REPORT

The patient was a well developed, well nourished, 21-year old white female with an essentially negative past history. She was quite certain that she had never suffered from any rheumatic fever or from any of the mechanical difficulties usually associated with poor cardiac function. The patient claimed to have been a very active young woman all her life and had played basketball during her high school years. She had had two previous pregnancies which were uncomplicated. Up until the onset of the present illness the patient had always been able to run up and down stairs never noticing any shortness of breath.

Approximately three and one-half weeks prior to her admission to the hospital, at which time she was entering into her fifth month of pregnancy, she suffered from what she considered a mild upper respiratory infection. This was characterized by cough and a very mild sore throat. She recalled no chills or fever.

After suffering from this infection for three or four days, the patient noticed the onset of a sudden, rather severe pain through the left chest. It was a startling experience and accompanied by much coughing, although there was no blood or blood-tinged sputum. She believed that there was some fever accompanying the attack. During the next week and a half she had alternating episodes of comfort with periods in which there was a great deal of left chest pain. Again, much coughing and probably fever. As the symptoms grew worse with respect to her chest discomfort and cough, she consulted her obstetrician who did a blood count and physical examination and noted that the patient was acutely ill with a hemoglobin of only 52 per cent. She was hospitalized immediately.

Upon her admission to the hospital she was seen to lie quietly in bed with the aid of one pillow, very pale, and breathing rapidly but easily. Her pulse was strong and regular at 120. Blood pressure was 105/70, temperature 100.2. Examination of the head was negative. Cervical veins were distended and pulsating. Lung fields were clear. The area of cardiac dullness was enlarged to the left anterior axillary line and the point of maximal impulse was felt faintly just medial to the anterior axillary line. Heart sounds were quite faint and there was a systolic grade 1 murmur heard at the apex. The abdomen was negative with the exception of the obvious 5 months' pregnancy. Lymphoid system, neuromuscular, extremities, and joints were negative.

An X-ray of the chest showed the heart to be quite large. The left border extended almost to the lateral chest wall and the pulsations were very feeble. There was some increase in the vascular lung markings and there was no displacement, either posteriorly or to the right of the barium filled esophagus. The electrocardiogram showed low voltage, a Q 3 which was 22 per cent of the value of the tallest R wave, flattened ST segments with inversion of T 2 and T 4. Laboratory findings were as follows: red blood cells 3,400,000, hemoglobin 9 grams, white blood cells 10,100, with leucocytes 60, segmented form, 20 "stab" form, 1 juvenile, 17 lymphocytes, and 2 monocytes. Sedimentation rate was 10 millimeters per hour. The nonprotein nitrogen was 30.5. Three blood cultures were negative for growth. The blood Kline test was negative. Urine was negative with the exception of a trace of albumin. Van den Bergh's test had a direct value of 0 and an indirect value of 0.15 milligrams per 100 cubic centimeters.

The diagnosis was considered to be acute pericarditis of a nonspecific or virus etiology with the possibility of an accompanying myocarditis.

During the next four days the following changes took place. The patient became more comfortable, most of the distention of the cervical veins disappeared, and the point of maximal impulse came back to an almost normal position. Some fine rales appeared at the right lung base which provoked us to use small doses of salyrgan® every two or three days and to digitalize the patient slowly. As the patient became digitalized the pulse gradually dropped to between 80 and 90, the heart sounds were more distinguishable, and a very rough almost continuous friction rub was heard along the left sternal border and at the apex. The temperature gradually dropped to normal and subnormal values and the dyspnea improved. During the first week of hospitalization, the patient was given a trial outside the oxygen chamber which did not prove satisfactory—consequently she remained in the oxygen chamber for several weeks.

A number of drugs and procedures were tried more or less empirically, and it is the writer's opinion that none of these exerted a beneficial effect on the patient's course. Among these empiric trials were a salt free diet, high doses of salicylates, iron, liver and folic acid oral preparations, penicillin, and ammonium chloride. We felt that the only real benefit was obtained from the oxygen, sedation and

Submitted March 13, 1950.

The Author

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rest; and the digitalis and salygran® were of value during her brief course of minimal heart failure.

After two weeks in the hospital she was quite comfortable and had no complaints. Temperature ran around 99, blood pressure normal, and the heart size, shape, and contour by fluoroscopy were within normal limits. However, by that time there was a very definite friction rub at the base of the heart with a grade 1 systolic murmur at the apex and a systolic murmur over the pulmonic valve area. There was no evidence of cardiac failure.

The laboratory work showed no remarkable changes with the exception that the red blood count had dropped to 2,600,000 with a hemoglobin of 8.5 grams, and it was felt that the patient's condition and particularly her lack of increased venous pressure, would permit the necessary transfusions. She received 2 whole blood transfusions three days apart and very slowly. No untoward effects were noted and the red blood count promptly ascended to 4,200,000 and the hemoglobin to 12 grams. She no longer required oxygen or digitalis and during the remainder of her hospital stay was maintained on complete bed rest with mild sedation.

Approximately 3 weeks after admission, she was discharged for home where she remained at almost complete bed rest until time for delivery. She had no complaints and her heart findings remained about the same for the following 2 months in that there was a grade 1 systolic murmur at the apex with a basilar friction rub and a basilar systolic grade 1 murmur. After about 2 months all abnormal heart sounds had disappeared with the exception of the grade 1 systolic murmur heard at the pulmonic valve area. In the meantime her red blood count had dropped from 4,300,000 to 3,600,000 and so, twenty days prior to her labor she was given another transfusion, slowly and without any difficulty.

Her labor was uncomplicated and she was delivered of a normal female infant.

At the time of this writing it has been one year and four months since her delivery. She has been checked repeatedly during that period and her electrocardiographic, fluoroscopic, and auscultatory findings have been completely normal.

DISCUSSION

It is the opinion of most cardiologists that the majority of cases of acute pericarditis with effusion of nonspecific or of a rheumatic origin in adults will eventually subside without the aid of too many dramatic therapeutic procedures. Hence it was more or less a safe conclusion that pericarditis at this particular time during the patient's pregnancy should not have any ill effects on her ultimate labor; presuming, of course, that good myocardial function with the absence of valvular damage would make its appearance at a safe time prior to the date of expected delivery.

It is interesting to speculate upon the etiology in this case, and it is presumed to fall into that category commonly known as either nonspecific or virus or idiopathic. Evidence to support this conclusion is as follows: 1. Acute pericarditis making its appearance for the first time in a normal adult heart and coming to a spontaneous remission is usually not thought to be rheumatic in origin; 2. To the best of our knowledge no valvular damage or myocardial damage of permanent nature persisted in this case; 3. Most of the sedimentation rates, PR intervals and other stigmata of rheumatic infection during the period of our patient's acute illness were within normal limits (although we should add that on one occasion the sedimentation rate went to 55 millimeters per hour).

SUMMARY

A case of acute pericarditis with effusion occurring during the fifth and sixth months of pregnancy is described.

REFERENCES

1. Hamilton, B. E.: Personal Communication.
2. Levine, S. A.: Personal Communication.
3. Hamilton, B. E., and Thompson, K. J.: The Heart in Pregnancy and the Childbearing Age. Boston, Little, Brown & Co., 1941.

Papaverine in Insulin Shock Therapy

Our observations clearly demonstrate that papaverine changes the course of hypoglycemia induced by insulin. In the high dosage in which papaverine has been employed in this study, a mild sedative action cannot be denied. Moreover, phenobarbital was found similarly effective in preventing hypoglycemic reactions with insulin dosage above control levels. Although the anticonvulsant effect of papaverine in these cases may have been in some measure sedative in nature, a cerebral vascular action may also have been operative. Certainly the occasional observation of transient hemiparesis, hemianesthesia, hemianopsia, conjugate deviation of the eyes, and sensory aphasia during hypoglycemic shock strongly suggests an underlying vascular derangement. Moreover, it is precisely for such symptoms that papaverine has been shown to exert great benefit in cases of hypertensive and arteriosclerotic encephalopathy. The drug would appear, therefore, to have value, not only in the prevention of the epileptic response to hypoglycemia but also as a prophylactic measure to avert cerebral vascular complications in patients with latent disturbance of the cerebral circulation. The influence of the drug in preventing ectopic beats by its quinidine-like action upon the myocardium would also seem desirable in insulin hypoglycemia in which cardiac irregularities are frequently encountered. Similarly, the coronary vasodilatation produced by papaverine would appear to be of further value in averting other cardiovascular complications which occasionally arise during this form of therapy.

From these considerations, it would seem that papaverine through its combination of effects is a unique drug for preventing undesirable reactions commonly observed in the course of insulin shock treatment for schizophrenia. In the dosage employed, no untoward side-reactions were encountered. Papaverine should be recognized as an effective anticonvulsant drug.—Doctors Russek, Zohman, and Tamarin, N. Y. State J. M., 50:2301, 1950.

Acute Fibrinous Bronchitis with Massive Atelectasis

FORREST W. MERICA, M. D.

THE occurrence of fibrinous bronchitis, especially when complicated by massive atelectasis, is so extremely rare that the following case, in an infant, seems worthy of report. A survey of the *Index Medicus* for the past twenty years yielded only one complete case report in the American periodical literature. This was published by Perlstein,[1] in 1930. In the third edition of their book, *Bronchoscopy, Esophagoscopy and Gastroscopy*, published in 1934, Jackson and Jackson[2] stated: "Two cases of fibrinous bronchitis have come to our clinic. One required bronchoscopic removal of plugs of membrane from the bronchi to relieve atelectasis. Both patients recovered without recurrence." They furnished no details of these cases. All the other cases of this condition listed in the *Index* were in the foreign literature, most of them in journals not accessible to me. Of the cases reviewed in detail, all were in adults, and hence the present case, in a boy, aged 20 months, is of exceptional interest.

Case Report.—A male infant, aged 20 months, was admitted to Lakewood Hospital on February 20, 1948, with fever and severe dyspnea. About five days before admission, the child had begun to have a harsh, non-productive cough which had become progressively more severe, but he had not appeared ill until the day before he entered the hospital. Then his temperature was 103.2°F., he became very short of breath, had gasping and grunting respirations, cried spasmodically and became slightly cyanotic. The parents were unable to give any information concerning the possible aspiration of a foreign body, except that about two weeks earlier, while eating a carrot, he seemed to choke and coughed for a few minutes afterward, but subsequently had had no cough until the onset of the present illness.

A tonsillectomy had been performed two months earlier because of frequent sore throats. Otherwise, the child had always been in good health. He had received the usual immunization and had not had any of the usual contagious diseases.

Physical examination showed that the child was well developed and well nourished, somewhat large for his age. He was moderately cyanotic and respirations were rapid, labored and grunting. He appeared acutely and severely ill. Examination of the neck showed no rigidity or adenopathy. The trachea was deviated slightly to the right. The chest was somewhat asymmetrical, with decreased costal excursion in the right upper region and increased flare of the right costal border. The entire lung field was dull to percussion, both anteriorly and posteriorly. Breath sounds were markedly decreased over the right upper lobe and were almost entirely absent over the right lower lobe. No rales were detected and the left lung fields were clear. The heart and mediastinum were both shifted to the right, and the heart rate was accelerated. The abdomen was not distended and showed no abnormal findings.

Roentgenographic examination of the chest showed the right hemithorax entirely opaque and the heart and trachea markedly retracted to the right, indicating virtually complete atelectasis of the right lung. The left lung was entirely clear. The findings suggested obstruction of the right main stem bronchus by a non-opaque foreign body.

Routine laboratory tests showed nothing significant, except for a slightly elevated leucocyte count of 11,450. The differential count showed 2 per cent eosinophils.

In view of these findings, bronchoscopy was performed immediately. A Jesberg bronchoscope (4 mm. 26 cm.) was used. When the carina was reached, the left main stem bronchus appeared clear. The right main stem bronchus contained some mucopurulent material which was aspirated. Then some whitish, heavier material appeared in the bronchus and was removed with a forceps. It was large and appeared to be fibrinous, somewhat resembling a piece of white cotton string. Then the aspirator was used and much heavy material passed through the tube into the wash bottle. The material sucked into the wash bottle appeared to be casts of the bronchial tree, formed of heavy, fibrinous material (figure 1).

Immediately after this heavy fibrinous plug had been removed, the child's breathing improved. Breath sounds came through in the lower lobe, and the mediastinum shifted to normal position, as did the heart.

The pathologist reported that the gross specimen (of the material removed from the bronchus) consisted of a number of pale gray masses with a root-like formation. They measured as much as 2.5 centimeters in over-all length, with the individual branches varying considerably. The maximal thickness was 1.5 millimeters. The tissue was moderately friable. Microscopic examination revealed irregular masses of fibrin, containing unusually large numbers of eosin-

Submitted Feb. 14, 1950.

The Author

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ophils, with numerous neutrophils and round cells. The pathologic diagnosis was fibrinous bronchial casts.

The child's recovery was rapid. Two days after the bronchoscopy, the respiratory rate was still slightly increased, but there was no cyanosis, his color was good and both sides of the chest were moving equally. There was no dullness on

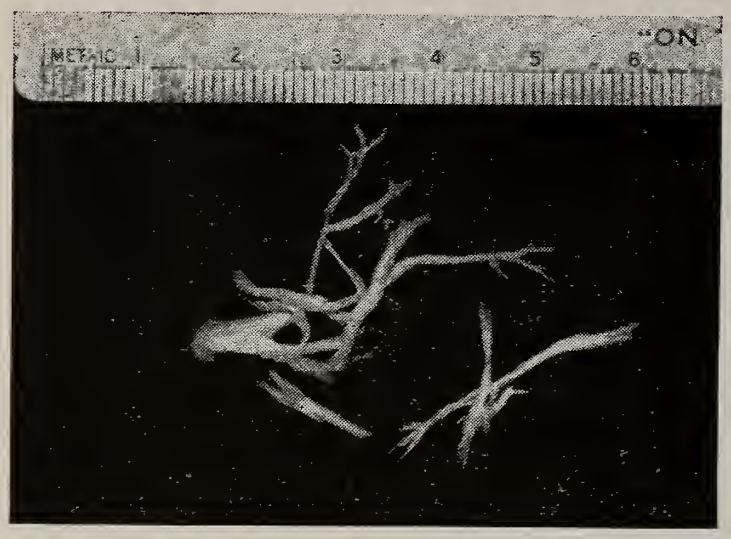


Figure 1. Gross specimen (fragmented) of fibrinous bronchial cast removed through the bronchoscope.

the right side of the thorax and breath sounds were clear and normal over the entire chest, with no rales. On March 1, 1948, nine days after admission, he was happy, eating well and his respiratory rate was normal; he was then dismissed from the hospital.

OTHER REPORTED CASES

In the case reported by Perlstein[1] the patient was a man, aged 54 years, whose diagnosis on admission was far-advanced tuberculosis. He had been feeling weak and losing weight for about a year. An exploratory laparotomy had been performed but nothing abnormal had been found. He began to have a paroxysmal cough, but brought up no sputum; a little later dyspnea, chills and cyanosis appeared. On admission, there were clinical signs of massive atelectasis. While a chest roentgenogram was being taken, the patient coughed up some blood-streaked sputum in which a bronchial cast was found, rolled up in a large ball of mucus. He felt better almost immediately, his temperature receded and he was up and about within a few days. For a few days after this episode, sputum expectorated showed fragments of casts consisting of strands of fibrin, containing no cells and no bacilli. The atelectasis disappeared completely. All sputum was negative for tubercle bacilli, though later roentgenograms of the chest showed suspicious markings in the upper lobes which pointed to a diagnosis of probable inactive tuberculosis.

Seiler[3] reported the case of a woman, aged 41 years, whom he treated with collapse therapy, after failure of medical treatment. About ten years earlier, she had had an illness which began with an apparently light cold and a questionable dry pleurisy, though there were no significant lung findings. Cough persisted for several weeks, and then the patient coughed up blood-streaked mucus plugs, containing "little branches" and her symptoms disappeared almost immediately. Later she had had several recurrences of this type of illness, always with improvement after coughing up plugs in the form of bronchial casts. When she consulted Seiler, at the age of 41, the manifestations had become more severe, and she complained of weakness and loss of weight, frequent paroxysms of coughing and dyspnea. In this case, material from the bronchus showed that it consisted principally of fibrin, with gram-positive cocci and leucocytes. There were no tubercle bacilli, no eosinophils or Charcot-Leyden crystals.

Rakower's[4] patient was a woman, aged 36 years, who had had three attacks of "grippe" during the past year with persistent dry, nonproductive coughing. On one occasion, when she was ill while visiting in the country, and had a severe pain in the chest which had been diagnosed by the local physician as left-sided pneumonia, she coughed up a large mucus plug which she described as being 10 to 12 centimeters long. After this episode, her condition improved, the pain in the chest disappeared, the cough subsided and the patient returned to her home. After the last attack of grippe, she had had a slight elevation of temperature and became increasingly dyspneic, with persistent coughing. After clinical and roentgenographic examinations which showed atelectasis, bronchoscopy was decided upon before making a definite diagnosis. While the patient was being prepared for bronchoscopy, she had a paroxysm of coughing and brought up a bronchial cast which measured 6 to 8 centimeters and was blood-streaked. The patient felt better almost immediately and recovered steadily. After two months, the lungs were almost entirely clear. The expectorated plug contained Charcot-Leyden crystals, a large number of eosinophils, leucocytes and epithelial cells. There were heterogeneous bacteria with a preponderance of gram-positive cocci.

Roth[5] reported the case of a woman, aged 56 years, who had had a persistent, non-productive cough for more than six months, with severe dyspnea. She was treated with torantil,® an antihistamine substance, and expectorated fibrinous plugs which relieved her symptoms.

Meyer's[6] patient was also a woman, aged 29 years, whose symptoms began during an attack of influenza. Her temperature never exceeded 38°C and she was not severely ill. She had a persistent cough, however, and during the third week began to cough up fibrinous material. The thickest specimen was about 2 millimeters and the longest about 4 centimeters. A culture of the material showed hemolytic streptococci and some white and yellow staphylococci. This patient's lung sounds were normal to percussion and auscultation throughout her illness. After getting rid of the fibrinous material, the patient improved and was up and about within a week. The sputum became like mucus instead of fibrinous.

Malamud and Lisman[7] observed a woman, aged 50 years, who, thirteen years previously, had had an acute pulmonary infection accompanied by profuse coughing and had expectorated long strings of mucus, with branches. She had recovered from that illness in about three weeks. When the authors observed her, she had been ill for four weeks, with cough, dyspnea, weakness, and malaise which had not responded to usual treatment. After two weeks, she had coughed up a large mucus plug, about 5 centimeters long, with branches, which had produced transitory improvement. Afterwards, the dyspnea and cough became more severe, with deterioration in her general condition, and she was admitted to the hospital. Examination showed a bronchitis which was apparently not

severe and atelectasis of the left pulmonary lobe. The patient coughed up abundant mucopurulent material, whose appearance did not attract attention, and then began to improve with complete recovery within a few weeks.

DISCUSSION

As already noted, the information on fibrinous bronchitis is extremely scanty, since the condition is of such rare occurrence, although the indications are that it is somewhat more frequent in Europe than in the United States. Such information as there is consists of individual case reports, scattered throughout the world literature. Perlstein[1] estimated in 1930 that about 175 cases had been reported and Seiler[3] estimated that there are only about a hundred.

The cause remains obscure, but allergy, diphtheria, tuberculosis, and influenzal infections are most frequently indicated. Perlstein reported that Shröder (1920) had found five cases among 4716 cases of pulmonary tuberculosis. In commenting on the possible etiology, Perlstein stated: "It is a matter of speculative importance whether fibrinous bronchitis is a metabolic disturbance of the bronchi, as suggested by Engel, or whether it is a response to infection or even to an altered, that is to say, increased coagulability of the blood serum. In any case, the association of the condition with tuberculosis, pneumonia and the broncho-asthmatic group, all of which are among our commonest fibrin-producing diseases, seems to be more than a fortuitous circumstance." Rakower concluded that two conditions contribute to the production of pseudomembranous bronchitis: (1) a constitutional diathesis and (2) some infectious, mechanical or physico-chemical agent. In the case he reported, the patient had a familial history of allergy and he considered a neurovegetative diathesis the primary cause but the precipitating agent was infectious (three attacks of grippe).

In my own case, the only finding which would suggest an allergic factor was an increased eosinophil count. There was no history of allergic symptoms and no clinical signs to suggest this. Since the case was of acute onset, it seems likely that it was produced by infection. The patient received penicillin and sulfadiazine during his stay in the hospital, and the febrile symptoms subsided promptly.

All authors recognize two forms of this condition, the acute and the chronic. The acute type is more serious; in this condition the mortality is estimated by different authors as 25 to 50 per cent. Some patients with the chronic type have had recurrent symptoms for years, even as long as 25 years.

It would appear from the literature that the condition is usually recognized after spontaneous expectoration of large bronchial plugs of fibrinous material. With the more widespread use of bronchoscopy, it may be that more of these cases will be recognized and relieved by aspiration of the fibrinous material through the bronchoscope.

Although atelectasis is a rare complication of this condition, especially in the more chronic cases, it was a feature in the clinical picture of four of the eight cases of other authors cited. Maxwell[8] also reported atelectasis in a case which was not fibrinous bronchitis but the bronchi were occluded by large mucous plugs.

Despite the extreme rarity of fibrinous bronchitis or of atelectasis resulting from bronchitis, the fact that it can occur should be kept in mind in any bizarre case of acute respiratory difficulty, especially in those with signs and symptoms of atelectasis. Consistent use of bronchoscopy in such instances might bring a few more of these cases to light.

SUMMARY

A case is reported of acute fibrinous bronchitis complicated by massive atelectasis of the right lung in an infant boy, aged 20 months. Cough had been present for five days, but the child had been acutely ill only for 24 hours before admission with severe dyspnea and cyanosis and signs of massive collapse of the lung. Removal through the bronchoscope of an occluding bronchial cast of fibrinous material brought immediate relief and led to an uneventful recovery.

Note: I am indebted to Dr. H. R. Hathaway of Lakewood, Ohio, for having diagnosed and referred this case.

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The Gallbladder and Common Duct Problem

The findings which we have regarded as criteria for opening the common duct are as follows: (1) A palpable stone in the duct. (2) Jaundice or a history of jaundice. (3) Abnormal dilatation of the duct. (4) A contracted gallbladder containing stones. (5) Multiple small stones in the gallbladder with an enlarged, patent cystic duct. (6) Flocculent bile in the duct, as shown by aspiration. (7) Gallstones associated with chills and fever.—Robert L. Sanders, M. D., J. Iowa State M. S., 40:437, 1950.

The Physician and Privileged Communications as They Relate To Mental State

E. H. CRAWFIS, M. D., LL. B.

INTRODUCTORY

THE average psychiatrist is averse to testifying in court, and avoids it as much as possible. In fact, many physicians, including psychiatrists, fear such an experience. However, at one time or another, situations will arise in which the psychiatrist is forced to appear and testify. Paranoid patients, those with postraumatic neuroses, or senile deteriorations, for example, may appear in any psychiatrist's office, be examined without any indication of possible litigation, and then within a period of several years the psychiatrist be called upon to testify as to the patient's mental condition, the cause of his illness, etc. Thus, in spite of aversion to court appearance, the chances of escaping completely are almost nil. For this reason, the psychiatrist needs to know something of his rights and privileges in court.

One of the important factors governing the physician's testimony is that of privileged or confidential communications. To most physicians, privileged communication is a vague phrase, and they have little understanding of this important property right, which belongs to the patient, and of the responsibilities of the physician, who is charged with the duty of observing the privilege. For this reason, I think that a discussion of the privilege as it applies to the physician, and to psychiatrists in particular, will prove valuable.

DUTY TO GIVE TESTIMONY

One of the fundamental maxims of the Anglo-American judicial system is that the public has a right to everyone's evidence. Our starting point is that there is a general duty to give whatever testimony one is capable of giving. Exemptions are exceptional and are limitations to the general rule. The privileged communications rule as applied to physician and patient is one of these exceptions to the general liability of every person to give testimony in court.[1]

BASIC PRINCIPLES

There are four fundamental conditions upon which the privilege is based.[1]

1. Communications must originate in the belief and confidence that they will not be disclosed.[2] Many diseases are not socially accepted, and the patient will go in for treatment only if he is sure that the doctor will not disclose his illness. This is especially true in psychiatry, where the community is not yet sufficiently enlightened as to mental illness.

2. The element of confidence must be essential to the maintenance of the relationship.

3. The relationship must be one in which the community is interested, and which it supports.

4. The injury to the relationship by the disclosure of communications must be greater than the benefit thereby gained for the correct disposal of litigation. Although individual injury may occur by reason of the withholding of information, the general benefit to most patients and to the Courts justifies the relationship.

HISTORY OF THE PRIVILEGE

In examining the history of privileged communication, we find the one of attorney and client to be the oldest. Under the English Common-Law Rules, no privilege was recognized as to communications between physician and patient. The privilege was established by statute in New York in 1828, and has been adopted by at least half of the states. We must be clear, therefore, that the privilege as applied to physician and patient is statutory, and we must examine the statutes in the particular state, in

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each individual case, to know whether the privilege exists or not.

ARGUMENTS AS TO THE PRIVILEGE

There are arguments as to the privilege. Some feel that it is unnecessary and should be eliminated. In some states where it applies, there have been efforts to abolish it.

The principal objection to the privilege is in personal injury cases and in cases involving industrial accidents. The claim is made that the privilege is used only to suppress the truth. In such cases the medical testimony is very important, and frequently the deciding factor. It is in this field that the greatest efforts are made to introduce testimony on the ground of waiver; that is, when the patient has impliedly relinquished the privilege, and those efforts are stoutly resisted. There are numerous conflicting decisions. The patient may waive his privilege and the Court can force the physician to testify. However, it is important to know that the physician does not have the power to waive the privilege.

It should be pointed out also that the privilege has been modified as to reporting of venereal disease, and also as to industrial accidents and illnesses. Here the privilege has been modified either by the exercise of police power, or by express waiver. The physician is required by health regulations to report certain infectious diseases. For example, reports are required by law or by official bodies. In the case of industrial illnesses and insurance policies, the privilege is expressly waived by the patient at the beginning of the relationship.

GENERAL STATEMENTS ABOUT PRIVILEGED COMMUNICATION

It is necessary that the relationship of physician and patient exist—a professional relationship, where the patient seeks treatment. The relationship may arise without the patient's permission, if unconscious and an emergency exists. The physician must be acting in his professional capacity, and information acquired when not employed as a physician is not privileged. The patient may waive the privilege. From the standpoint of the attorney, this is probably the most interesting phase of privilege. The waiver may be expressly stated as in insurance policies, and may arise because the patient sues the physician for malpractice, or merely calls the physician as a witness in a case involving the patient's illness.

PRIVILEGE AS APPLIED TO MENTAL STATE

To the psychiatrist, the question of privilege presents some special problems. One of these is that of testifying as to mental condition. This stems from the fact that, in earlier cases, sanity or insanity was not regarded as a medical problem. There are cases in which the family physician has been called to testify as to his patient's medical condition, although other information known by the physician was considered privileged. Other cases reach the opposite conclusion. The same applies to psychiatrists. However, in reading the more recent cases, I believe that the trend is definitely toward accepting the viewpoint that as to his patient's mental condition the privilege applies to the psychiatrist. If you are called to testify as to information received from your patient, or his mental condition, you should regard this as a privileged communication, and should not testify unless the privilege is waived, or you have been instructed to testify by the Court.

PRIVILEGE DOES NOT APPLY IF EXAMINATION ORDERED

Where the examination of the patient has been ordered by the Court, or for the opponent in civil litigation, since no professional relationship applies, the privilege does not apply. Also, in expert testimony, the hypothetical question does not involve the privilege.

PRIVILEGE AS APPLIED TO HOSPITAL RECORDS

Apparently there is no question that the privilege includes medical records, and hospital records.[2] However, in the case of a public hospital, we are not so clear. In Ohio, for example, we have conflicting decisions as to whether the privilege attaches to public health institutions. The most recent decision states that the holding is for the privilige in the majority of jurisdictions. The New York Courts have reached a directly opposite decision, and hold that the physician-patient relationship does not apply in State Hospitals. I think that it is important for us to know that this rule would not be applied in Ohio, and that the physician-patient relationship is the same in our State Hospitals as in general hospitals or private practice.

It should be made clear that the privilege applies to the communication itself, and not to the fact that a communication was made. The date of an examination, number of office visits, etc., are not privileged.

In applying these rules to hospital records then, we see that ordinary facts as observed by lay persons are admissible. Date of admission, discharge, and other statistical data clearly are not controversial. Others, such as observation of "odor of alcohol on breath"; "patient was delirious 4 hours before accident"; "patient's vomitus had odor of whiskey"; record showing unruly behavior of patient and disobedience of orders of surgeons and nurses——all have been held admissible, that is, not within the privilege.

However, the history and examination or progress notes as recorded by intern, resident,

or medical officer, are privileged, and the Court should be consulted before testifying on such matters. In State Hospitals, where the diagnosis and condition of the patient are reported to the committing court, they are public record and cannot be considered privileged.

PRIVILEGE MAY OR MAY NOT APPLY IN CRIMINAL CASES

The privilege has been held to apply in criminal as well as civil cases. However, the Courts do not like its effects, feeling that justice will not be done in many instances, and have taken various methods to circumvent its application. In California, the statute expressly limits it to civil cases.

INVOLVING TESTATOR'S MENTAL CAPACITY PRIVILEGE USUALLY DOES NOT APPLY

There are a considerable number of cases involving will contests, and the testator's mental capacity. However, in referring to the physician's testimony it is apparent that usually the family physician, and not a psychiatrist, was involved. In some cases the question of waiver of privilege was argued. Generally, however, the decision has been reached that the physician could testify on testator's mental condition because this was not a part of the medical situation; that is, he was not under treatment for mental illness.

It should be pointed out that the requirements for mental capacity to make a will are not the same as those used in judging either competency or insanity in the legal sense. It is possible for a person to be legally insane or incompetent and still be considered as able to make a valid will. In almost all cases, one can assume that questions involving mental capacity to make a will do not come within the area of privileged communications. I think that it is important for the psychiatrist to remember that insanity in the legal sense is not synonymous with psychosis. The Courts are interested only in competency or responsibility.

Generally speaking, the Court considers the terms insanity and psychosis as synonymous, and yet they are not. In civil cases the test primarily is competency, that is, the ability to manage one's own financial affairs. On the criminal side the measurement primarily is the ability to form the intent to commit crime. I am sure that all psychiatrists know many psychotic patients, who are competent and able to manage their own affairs.

POSSIBILITY OF PHYSICIANS BEING SUED FOR BREACH OF PRIVILEGE

There are a number of cases in which physicians have been sued for libel or slander, based upon the disclosure of information covered by the privilege.[3] Such disclosure, either oral or written, must expose the person to contempt or ridicule and injure him in his occupation. Usually such cases have been based upon disclosures of venereal disease, but all physicians should remember such a possibility in discussing their cases before groups. In presenting case histories, photographs, etc., care must be used in concealing the identity of patients.

Testimony given by a physician in court on confidential information is not a breach of the privilege, and no liability is incurred for this reason. Also, filing of various official reports required by law does not make the physician liable.

BREACH OF PRIVILEGE AS TO RECORDS AND RELEASE OF INFORMATION

Liability for breach of the privilege must also be considered when requests for information come to the physician, or requests to the hospital for examination of records, or copies of records.

Most hospital administrators are aware of the necessity of a signed release by the patient, his guardian, widow, heir, etc. Such release must be kept on file with the record. In the situation where residents or medical staff members wish to use records for research or preparation of papers, authorization for use of records is obtained from the hospital rather than the patient. No privilege or waiver is involved if the identity of the patient is not disclosed.

Abstracts, summaries, etc., supplied to hospitals and attending physicians, are usually a matter of courtesy, and release or authorization is not required.

A frequent problem encountered in hospitals is a request to examine records by insurance men, or attorneys, with a signed release by the patient. In many instances, it is customary for the hospital to permit this. We do not agree with this practice. It should be pointed out that the record is the property of the hospital, not the patient, and that a signed authorization is only a waiver of privileged communication. It is much better practice to answer questions from the record than to allow free examination.

There are several objections to such examination: First, there is the possibility of alteration; Second, the names of residents or interns are frequently obtained, and they are subsequently subpoenaed; Third, lay persons may misinterpret statements in the record, giving rise to needless litigation; Finally, in State Hospitals or in private sanitariums, the competency of the patient may be questionable. Certainly in the case of State Hospitals, where patients are committed by the Court and thereby automatically declared incompetent, a waiver by such a patient would be invalid. For this reason, I strongly advise that a more careful check be kept on the access to hospital records.

Finally, the psychiatrist should be reminded that even though he is not paid, the privilege

is not waived.[4] Just as in malpractice cases, the basic principle is protection of the patient, and those patients treated without charge are protected as well as those who pay.

SUMMARY

1. There is considerable variation in the application of the rule of privileged communications; in Ohio it is established by statute. There are arguments as to whether it is justified but as long as it is in the statutes we must accept it.

2. When the psychiatrist testifies as to his patient's mental condition, the privileged communications rule applies.

3. The rule applies to hospital records, and in Ohio to State Hospital records.

4. The rule probably does not apply in testifying as to mental capacity to make a will.

5. Knowledge of the rule is important to prevent suits against the physician either on the basis of his private records, or those in the hospital.

6. In permitting examination of the patient's record, the rule of privileged communications should be considered.

And in conclusion, some general knowledge of his legal rights and liabilities is a necessary part of every psychiatrist's equipment. Much as he would like, he cannot completely avoid legal complications in the present day practice of psychiatry.

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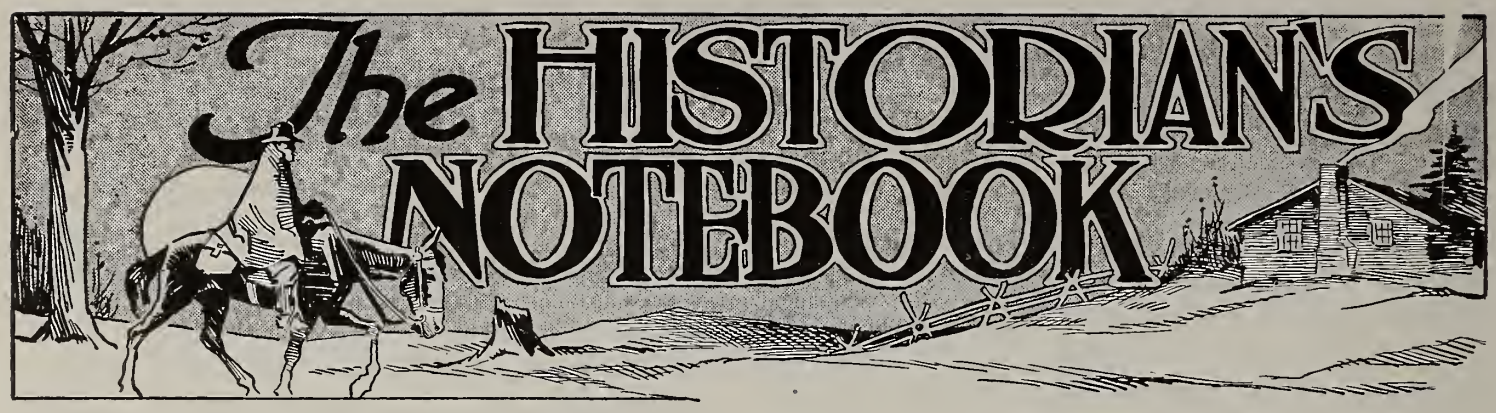
Bronchiectasis

Bronchiectasis is a common disease which has been overlooked, wrongly diagnosed and poorly treated by a majority of medical men for many years. Too often children with typical pictures of bronchiectasis have been diagnosed as chronic bronchitis or their parents have been told that the child's cough was habitual and that he or she would eventually outgrow it . . . Bronchiectasis is a common disease which usually develops after pertussis, pneumonia or measles, or a combination of these diseases . . . If it should develop, the patient should be studied with the thought of elimination of the disease by surgery. Surgery is urgent since a high percentage of patients who develop bronchiectasis before the age of 10 years are dead of the disease or its complications before the age of 40 years. The risk of lobectomy (even bilateral) or pneumonectomy is slight compared to the risk of the patient keeping his diseased lung tissue.—Ralph A. Dorner, M. D., J. Iowa S. M. A., 40:290, 1950.

Nephritis

As the acute nephritis becomes better and the urinary and other findings begin to disappear, the proteins are graually increased up to a normal intake of 1 Gm. or more per kilogram per day . . . Salt should be restored gradually when edema disappears, to avoid recurrence of edema. We usually increase their intake by 2 Gm. for two to three days. If there is no increase in edema or weight and no decrease in urinary output or rise in blood pressure, the salt is increased to 5 Gm. a day and eventually a normal quantity is permissible.

As glomerulonephritis progresses and the patient passes into the nephrotic phase, one is confronted with a problem which is quite different from that of the acute phase. For in this stage of the disease the patient may not have hypertension, or hematuria, or nitrogen retention, but does have marked edema, hypercholesterolemia, albumin globulin reversal, and large quantities of albumin in the urine, at times as high as 20 to 40 Gm. per 24 hours. Nephrosis is one of the stages through which glomerulonephritis may progress and is also regularly encountered in amyloid degeneration of the kidneys. Its effect on water and salt metabolism is essentially the same, regardless of its origin. In the treatment we attempt, first, to promote diuresis and, secondly, to correct the hypoalbuminemia. Salt restriction is preeminent and this has to be rigid. The extensive edema in these patients is on the basis of a depletion of the serum albumin, and we try to improve this factor by dietary management. These patients are given diets high in protein up to 3 Gm. per kilogram. It is difficult to raise the protein level in the blood if excretion is 10 Gm. of protein or greater; if 15 Gm. or over, it is impossible to build the serum albumin content by diet. Nevertheless, depletion of serum albumin means depletion of all protein stores in the body, and protein feeding is the only way we can keep up the patient's nutrition until nature comes to his rescue. Nature then may heal the glomeruli through which this large quantity of protein is leaking, or a fibrosis of these glomeruli may result and the protein loss is stopped. But in reality the kidney has been more extensively damaged. Intravenous protein hydrolysate or amino acids are of no value in attempting to build up the protein depletion. These are of value only in correcting the nitrogen crises which result from depletion of plasma nitrogen, as demonstrated by Fahr. Some may wonder about the use of concentrated salt-free serum albumin at this stage. We feel this is not advisable, as it is excreted as quickly as it is administered and is too closely to be eliminated in the urine.—B. J. Peters, M. D., Wisconsin M. J., 49:791, 1950.



Development of Dermatology in Ohio

Part II

LEON GOLDMAN, M. D.

(Concluded from the October Issue)

THEN in these three medical centers in Ohio the burden of undergraduate and later postgraduate dermatologic teaching was undertaken by these part-time teachers and always busy practitioners. They were the type of clinicians that Bechet mentioned and they were not only important in their local scene, but they influenced American Dermatology. Ravogli helped to found the Section of Dermatology and Syphilology of the American Medical Association in 1887 and was its host in Cincinnati and in its first meeting on May 8, 1888, when Corlett was its first secretary. Later Ravogli became its chairman in 1897. Ravogli was also president of the American Dermatological Association in 1916. In addition to the national importance of his services in developing postgraduate training in Cleveland, Harold Cole was and is a foremost syphilologist in this country and his work with Sollmann was responsible for the clinical implications of the pharmacology of the heavy metals available for the therapy of syphilis in those days. Even today, the maintained close associations of syphilology with dermatology in Cleveland and Cincinnati is unfortunately not held as a united front on the rest of the American scene.

IN CINCINNATI AND CLEVELAND

The result of such teaching centers was the development of men interested in dermatology, specializing in dermatology and even serving as teachers. The rise of such centers in the United States made it unnecessary to go to Europe for training in diseases of the skin. The dermatologists in those centers, especially in Cleveland and Cincinnati, assisted in the development of their respective groups. Without such assistance, the directors could have never maintained such teaching and research activities. The men in Cleveland consisted of John Rauschkolb, John Gammel, Hagobe Miskjian, George Binkley, Herbert Johnson and others. In Cincinnati the succession of outstanding men included Edward Shields, Charles Tabb Pearce, Meyer L. Heidingsfeld who later became professor of dermatology and died September 3, 1918, and then was succeeded by Elmore Tauber who developed the service at the Cincinnati General Hospital, and then by Harry Claassen, respectively, as professor of dermatology in the College of Medicine of the University of Cincinnati and as director of the service at the Cincinnati General Hospital.

In Cincinnati, the two medical colleges, Miami and Ohio Medical College were combined in 1909. Cleveland Medical Department of Ohio Wesleyan University was later taken over by

From the Department of Dermatology and Syphilology of the College of Medicine of the University of Cincinnati and the Cincinnati General Hospital. Presented at Ohio State Archeological and Historical Society Annual Meeting, Columbus, April 14, 1950.

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Western Reserve University in 1910. The professor of dermatology there before the merger was Dr. Harry B. Kurtz. Some dermatologic teaching was done also in the homeopathic medical schools both in Cleveland and in Cincinnati. Later as part of the development on the national scene, Ohio participated in the founding of the large clinic type of practice and the Cleveland Clinic in 1923 soon after its inception, had a Department of Dermatology and Syphilology and Earl W. Netherton was placed in charge. Later George M. Curtis came as his assistant.

DEPARTMENTS DEVELOPED

Now with the increasing age of specialism, we find that large active hospitals developed departments of dermatology. These were important for the teaching, not only of the resident staff of the particular hospital, but for those who were associated with medical college for undergraduate teaching. They were instrumental in the development of postgraduate teaching for the specialists in training and for the practicing dermatologists in their respective staffs. The interest and value of such a specialty service was dependent upon such factors as the interest of the hospital in developing such services, the allocation of in-patient beds, the interest (as opposed to "inertia") of the visiting dermatologists. In Cleveland, some of these hospital services may be mentioned because they were actually active training centers.

In 1917 Mt. Sinai Hospital had a night clinic for urology, syphilis, and venereal diseases under Dr. Philip Jacobs. In 1919 Dr. Benjamine Levine organized a day clinic and included dermatology. Later he was joined by Dr. J. E. Fisher and Dr. Sidney Littman. In St. Vincent's Charity Hospital, the service originally developed by Dr. Heithaus was later continued by Dr. Cummer and Dr. LaRocco. The St. Luke's Hospital service developed by Dr. Robert E. Binkley, who was later succeeded by Dr. Herbert Johnson. St. Alexis Hospital had Dr. Clyde Cummer as visiting dermatologist about 1925. Later John Rauschkolb developed an outpatient dispensary there. Claude Norris in Youngstown and Howard Parkhurst in Toledo are prominent in the national scene.

SPECIALTY SOCIETIES

One other factor in the development of dermatology in Ohio was the development of the specialty medical society. Strange at times may be some of the uses to which this type of society may be bent, yet its primary function was and continues to be that of postgraduate teaching. For those of us who are not familiar with the mechanics of such a society, it may be well to add that ordinarily its program includes the exhibition of clinical cases whose diagnosis is to be established or special treatment procedures to be demonstrated. The cases are discussed then in detail. In any postgraduate program this is a very important part of practice. In 1948 the Cleveland Dermatological Society celebrated its Twenty-Fifth Anniversary. The names of doctors who were charter members follow: C. L. Baskin, W. T. Corlett, H. N. Cole, J. R. Driver, J. E. Fisher, W. C. Gill, A. H. Heithaus, H. B. Kurtz, C. G. LaRocco, B. Levine, S. Littman, H. J. Parkhurst, L. W. Potts, C. J. Shepard, E. I. Steinberg, K. G. Zwick.

In 1950 the Cincinnati Dermatological Society had its Twenty-Fifth Anniversary. Its charter members were: Doctors Charles J. Broeman, Harry L. Claassen, Ralph R. DuCasse, George Holt, H. Jerry Lavender, James Miller, Abe W. Nelson, C. Tabb Pearce, Augustus Ravogli, Elmore B. Tauber, Karl G. Zwick. In this connection one may point out that Zwick was a charter member of both dermatological societies.

These specialty societies were instrumental in the development of more extensive specialty society groupings on a national scale. In 1927 Cincinnati joined with Cleveland, Pittsburgh and Detroit to form the Four Cities Dermatological Association, now the greatly enlarged and active Central States Dermatological Association. Cincinnati later was part of the Mississippi Valley Dermatological Association. In spite of the rise of other national specialty societies and the consequent increases in meeting periods and increase in programs, the Central States Dermatological Association has become an important group in the Midwestern dermatology. The specialist depends on these societies for his own continued teaching and professional contacts.

During World War II, accelerated undergraduate teaching programs combined with severely reduced teaching departments and increased burdens of private practice produced a complex and fatiguing mixture scarcely encouraging any scientific advances in dermatology. In addition, research towards the war effort was carried out at the various dermatologic centers. In Cincinnati, the Department of Dermatology, together with the Kettering Laboratory of Applied Physiology of the College of Medicine, gave instructional courses on a national scale on civilian defense against chemical warfare.

Now the teaching centers in Cleveland, Cincinnati and Columbus continued to expand under the pressure of the increasing numbers of physicians interested in training in dermatology. Some of these had started training before going into the Armed Services, others became enamored of this specialty (or specialism in general) while in service. Dr. Eldred Heisel became head of the Department of Dermatology at Ohio State University.

The **1948 Book of the American Board of Dermatology and Syphilology** listed Cleveland

City Hospital and the University Hospitals of that city and the Cincinnati General Hospital as accredited institutions for three year training and the Cleveland Clinic Foundation Hospital for a two-year training program.

DISTRIBUTION BROADENS

The current picture in dermatology in Ohio, as in the national scene, is the gradual movement of well trained and capable specialists to smaller communities. So, in addition to Cleveland and Cincinnati, the American Board diplomates of dermatology are found in many of the cities of Ohio. In the last issue of the American Board of Dermatology, graduates were listed for Akron, Canton, Cincinnati, Cleveland, Columbus, Dayton, Lima, Middletown, Toledo and Youngstown.

Important now in postgraduate training in dermatology in the United States is the American Academy of Dermatology. Clyde Cummer of Cleveland was honored as president in 1948 and now John E. Rauschkolb of Cleveland is serving as assistant secretary-treasurer.

Now dermatologists in Ohio are part of the turmoil of the national scene. One of the currents is the rewakening of the social responsibility of the physician. Perhaps an illustration of this was the almost complete neglect previously of the public health aspects of syphilis by the practitioner, including the dermatologists. By his interest and his work, Harold Cole was the exception here, but the disinterest of the rank and file led the Public Health Service, of necessity, to its great role in the field of venereal disease control. Perhaps this will be a lesson for us in practice. Now, the dermatologist in Ohio is active in the cancer control program. We must assume the initiative where needed. This is the age truly of preventive medicine and dermatology has much to offer for this, for preventive and dynamic dermatology are the basis of training for the young dermatologist now in Ohio. Thus we hope to make him of tough fiber to understand and to strive and to succeed in this period of the tempting theory of easier security by rules rather than security by hard work. There is always much to be done.

In the eighteenth century, Percival Pott wrote the first detailed description of an occupational cancer. So doing, he interpreted to the medical world a class of neoplasms which, in later times, was destined to have an ever-increasing significance. For with the rise of industry there has been a corresponding rise in the incidence of industrial cancers. This fact, of course, is important. But it is not nearly so important as the fact that industrial cancers can be prevented. They need never exist.—The Cancer Bulletin 2:27, 1950.

KEEPING UP WITH MEDICINE

• CASE-FINDING surveys of adult groups indicate that examination of adults is much more profitable than examination of preadolescent and adolescent children.

* * *

• TODAY we hear less of gluttony and of drinking to excess as being the inevitable precursor of an attack of gout and more charitable views include trauma, fatigue, stress, allergic and psychic factors, among the precipitating causes of an attack.

* * *

• THEY are now saying that it is unwise to attempt treatment in cases of azoospermia and oligospermia without first performing a testicular biopsy, which after all is a minor operation.

* * *

• ANOXIA produces an increase in lymph flow and excessive bronchial secretions.

* * *

• MEDICINE cannot in the long run increase the population of the world. The consequence of the diminished death rate which our medical missionaries have accomplished in India and China is that persons whose lives have thus been saved must die of starvation a few years later.

* * *

• IT has been reported that the toxicity of ephedrine is nearly tripled by the concomitant action of moderate doses of theophylline ethylenediamine and that conversely the toxicity of aminophylline is nearly doubled by the concomitant action of moderate doses of ephedrine.

* * *

• POSTURE plays a leading role in preventive medicine; its effects are far reaching. We physicians should pay more attention to it.

* * *

• IN a recent survey of the dietaries of 402 pregnant women in a typical southern rural area only 6 per cent were receiving the recommended allowances of specific nutrient for pregnancy.

* * *

• THE average length of life of white women in the United States is now at the new high of 71 years; the average of white males is 65.5 years.

* * *

• IN our society eating has become a condition reflex independent of the body needs. The reduction program for the obese patient therefore becomes one of reconditioning the reflex.

* * *

• ONE hundred forty-six cases of methemoglobinemia with 14 deaths, due to nitrates in the drinking water have been reported from rural Minnesota.—J. F.

Proceedings of The Council . . .

Civilian-Military Coordination of Doctor Supply Is Only One of Many Matters of Importance to Profession Taken Up at Two-Day Conference

FOLLOWING is an abstract of the minutes of meetings of The Council of the Ohio State Medical Association held at the Granville Inn, Granville, Ohio, Saturday and Sunday, September 16 and 17, 1950.

All members of The Council were present except Dr. J. Craig Bowman, Upper Sandusky, councilor of the Third District. Others attending included A. M. A. delegates and the chairmen of a number of Association committees.

After the meeting had been called to order by Dr. Swartz, President, The Council adopted a resolution of sympathy regarding the death of the mother of Dr. A. A. Brindley, Toledo, a past-president and A. M. A. delegate, and instructed the executive secretary to convey to Dr. Brindley a message of sympathy and condolence.

The executive secretary reported as follows on membership: Total membership as of September 15, 1950, 7,463, compared to a total membership of 7,479 as of December 31, 1949.

WAIVER OF DUES

The question of waiving dues for members entering military service as a result of the national emergency was discussed. On **motion** duly made, seconded and unanimously **carried**, The Council adopted the following policy:

1. State Association dues for the balance of 1950 shall be waived for new members who have entered active military service on a temporary basis because of the national emergency.
2. State Association dues for 1951 shall be waived for members who entered active military service on a temporary basis in 1950 because of the national emergency.
3. State Association dues for 1951 shall be waived for physicians who were members of the Association in 1950 and who enter active military service on a temporary basis because of the national emergency prior to the payment of 1951 State Association dues.
4. The Secretary-Treasurer of each County Medical Society shall be requested to cooperate with the Columbus Office of the Association in assembling the names of physicians entitled to waiver of dues under the foregoing provisions.

A. M. A. DUES

The executive secretary was instructed to collect 1951 A. M. A. dues in the manner used for the collection of 1950 A. M. A. dues; namely, by billing members direct at the time a State Association membership card is mailed to them.

Correspondence from a number of members, asking about eligibility for associate fellowship in the A. M. A., was reviewed. The executive secretary was instructed to advise members regarding the provisions for associate fellowship in the A. M. A.; and that those who considered themselves eligible for such type of membership should file applications with the Columbus office for review by The Council.

The finances of the Association and *The Journal* were reviewed. The executive secretary advised The Council that due to an increase in costs of producing *The Journal* and because of the purchase of additional office equipment, it would be necessary for the State Association to provide increased funds for *The Journal.* On **motion** duly made, seconded and unanimously **carried**, an additional amount of $10,000 was appropriated for *The Journal* account and the equipment purchases made during the year **were approved.**

Mr. Nelson and Mr. Saville reported on the pre-election conferences held to date and on those scheduled to be held prior to October 1.

MEDICAL SERVICE PLAN

Dr. Mundy presented and discussed a report from the Committee on Medical Service Plans, based on the minutes of a meeting of that committee held on August 13, 1950.

During the discussion Dr. Heusinkveld filed with The Council a letter tansmitted to him under date of September 12, 1950, by Mr. James E. Stuart, executive director, Hospital Care Corporation, Cincinnati.

After an extended discussion of the recommendations of the Committee on Medical Service Plans, The Council adopted by unanimous vote the following resolution:

> "Resolved, That The Council approve in principle the issuance by Ohio Medical Indemnity, Inc., of a service contract for families whose income does not exceed $4,000 per year, and for unmarried persons whose income does not exceed $2400 a year."

A motion recommending that obstetrical services be provided on an indemnity basis for subscribers to the family or individual service contracts was **carried** by a vote of 11 to 3.

By unanimous vote The Council adopted the following motion:

> "That the service contracts provide that the amount paid for tonsillectomies shall be either $40 for subscribers under 12 years of

age and $50 for subscribers over 12 years of age, or $45 regardless of age, whichever provision is found to be acceptable from an actuarial and sales point of view.

By a unanimous vote The Council adopted a motion referring the foregoing recommendations to the Board of Directors of Ohio Medical Indemnity, Inc., with a request that a service contract be prepared on the basis of the principles set forth in these actions, together with a fee schedule for professional services and a schedule of premiums, and that the recommendations of the Board of Directors of O. M. I. be considered by The Council at its next meeting.

The Council then adopted a motion accepting the report of the Committee on Medical Service Plans, ordering it filed, and expressing appreciation to the committee for its excellent work.

Acting on behalf of the Ohio State Medical Association, a shareholder of Ohio Medical Indemnity, Inc., The Council approved the action of the Board of Directors of O. M. I., authorizing an additional subscription not to exceed $15,000 to Blue Shield Medical Care Plans to be used in effecting early incorporation of a Blue Shield National Service Agency.

THE NATIONAL EMERGENCY

Lengthy consideration was given to the national emergency and the mobilization of medical personnel for the armed forces. In order to establish machinery whereby the Association could play an important part in coordinating the needs of the military forces for medical officers and the health needs of all communities of the state, including the needs of hospitals, medical schools and other institutions for adequate civilian medical service, The Council took the following action:

Authorized the reorganization of the Committee on National Emergency Medical Service as follows:

1. Designated Dr. Robert Conard, Wilmington, and Dr. C. C. Sherburne, Columbus, as co-chairmen of the Committee on National Emergency Medical Service.
2. Designated Dr. Conard as chairman of a newly created section of that committee to be known as the Military Advisory Committee.
3. Designated Dr. Sherburne to continue as chairman of the civil defense section of the committee, the personnel of that section to consist of the following physicians who are at present members of the Committee on National Emergency Medical Service: Dr. Fred Berlin, Lima; Dr. Morris G. Carmody, Painesville; Dr. Carl R. Damron, Mansfield; Dr. Drew L. Davies, Columbus; Dr. William J. Graf, Cincinnati; Dr. Harry R. Huston, Dayton; Dr. Maurice M. Kane, Greenville; Dr. E. A. Ockuly, Toledo; Dr. Claude S. Perry, Columbus; Dr. W. O. Ramey, Cincinnati; Dr. George L. Sackett, Cleveland; Dr. Robert E. Tschantz, Canton; Dr. Cyrus R. Wood, Port Clinton; Dr. Herbert B. Wright, Cleveland; Dr. Robert M. Zollinger, Columbus.

Authorized the president to appoint 11 physicians as members of the Military Advisory Committee under the chairmanship of Dr. Conard, each to represent one of the eleven Councilor Districts of the Association.

Authorized the employment of Dr. Conard on a full-time basis, with offices in the Columbus office of the Association, to handle all administrative details for the Military Advisory Committee and to assist on administrative details in connection with the work of the Civil Defense Committee.

Instructed the president to issue a request to all county medical societies to designate a new committee or an existing committee as a Military Advisory Committee to work with the State Association Military Advisory Committee on all matters wherein the State Association Committee would need factual material and advice regarding the availability or essentiality of local physicians for military service or for civilian service.

CIVIL DEFENSE

A report on civil defense activities in Ohio to date was made by Dr. Sherburne, Dr. Conard, Dr. Swartz and the executive secretary. Details of the Ohio Civil Defense program were reviewed and plans for placing the program into operation were discussed.

Dr. Swartz and Dr. Conard reported on temporary procedures which had been followed in consultations with the Army on the matter of recalling medical reserve officers for active duty. It was pointed out that these responsibilities would now be handled by Dr. Conard and the newly created Military Advisory Committee.

PUBLIC HEALTH REPORT

The Council then reviewed, paragraph by paragraph, the second report issued recently by the Ohio Committee on Public Health relating to local health departments. The following actions were taken on the principal recommendations of the Ohio Committee on Public Health:

On the matter of reducing the number of local health districts, The Council expressed itself as favoring the recommendations in the following order:

1. That the county be made the basic health unit with a permissive clause for cooperative plans between counties.

2. That the Council would favor as an alternative, the proposal that the county be made the

basic health unit with all municipalities included except those over 100,000 population.

On the matter of revising the procedure for the selection of members of a local board of health, The Council expressed itself as believing that the most desirable method would be to provide for the appointment of the board of health by the county commissioners. It expressed itself as believing it would be more desirable to leave the present procedure unchanged than to provide for election of members of the board of health by voters of the county.

With respect to proposals which would provide more local funds for public health activities, The Council expressed itself as believing that a method to provide for an appropriation from the county general funds would be desirable. However, The Council felt that it could not take too definite a stand on the financial recommendations because of a lack of adequate information and advice. It suggested that further study be given to the question of finances.

With respect to the recommendations on the distribution of the state subsidy to local health departments, The Council approved all of the recommendations set forth in the committee's report.

COMMITTEE REPORTS

Mr. Page, secretary of the Committee on Rural Health, reported for that committee, which report was approved and ordered filed. The Council expressed itself as believing that the proposed conference with interns, residents and medical students in the Cincinnati area should be held as planned by the committee.

Dr. Wilzbach reported on the activities of the Committee on Education, of which he is chairman. There was a general discussion in which some members of The Council stated that they felt there is a need in Ohio for more postgraduate programs, primarily programs which would provide resident training at the medical schools for physicians in private practice who are desirous of taking refresher work.

Mr. Saville, director of the Department of Public Relations, presented a lengthy report on the newspaper advertising and radio programs which will be carried on in October as a part of the National educational program of the American Medical Association. Several motion pictures were shown for review by The Council. By official action, The Council decided that the Association should not at this time sponsor films for showing in public theaters.

Dr. Diethelm, chairman of the Committee on Scientific Work, discussed with The Council the question of the program for the 1951 Annual Meeting. The Council suggested that the committee work out a program which would be along the same lines as the program presented at the 1950 Annual Meeting in Cleveland.

HOSPITAL PROBLEM

Dr. Worstell, chairman of the Committee on Industrial Health and Workmen's Compensation, reported on conferences which had been held with representatives of the Ohio Society of Anesthesiologists and the Ohio Hospital Association relating to a new section of the hospital contract issued by The State Industrial Commission, under which a hospital may elect to provide anesthesia services as a part of the hospital's services covered by the per diem rate paid by the Commission for hospitalization of Workmen's Compensation cases. He advised The Council that suggested changes in the contract which had been agreed to informally at these conferences had been rejected by the Board of Trustees of the Ohio Hospital Association. On motion duly made, seconded and unanimously carried, this question was referred back to the Committee on Industrial Health and Workmen's Compensation for further conferences with representatives of the Ohio Society of Anesthesiologists, and that the principles set forth in the recent action of the House of Delegates of the American Medical Association pertaining to the practice of medicine by hospitals should be taken into consideration by the committee in its future deliberations.

Dr. Worstell also reported on conferences he had attended as official representative of the Association on the matter of compulsory disability insurance.

Dr. Dixon and the executive secretary reported to The Council on plans to date for the clinical session of the American Medical Association to be held in Cleveland, December 5-8, 1950.

V. A. CASE REVIEWED

The Council then considered a dispute between a member of the Association and the Veterans Administration on the handling of the case of a veteran suffering from multiple sclerosis and which had been submitted to The Council for arbitration. Statements submitted by the physician and the Veterans Administration, together with statements submitted by several physicians who had been selected by The Council to review the file, were studied and discussed.

By unanimous vote The Council adopted the following statement:

> "There is no known cure for multiple sclerosis. These patients are seriously ill and can have intervening illnesses of other types—perhaps they are even more likely to have such intervening illnesses than a healthy individual. Therefore, such patients should be under medical supervision. Inasmuch as there is a difference of opinion between medical authorities in the case sub-

mitted to The Council for arbitration, The Council recommends that the patient involved be referred to a hospital for further study and consultation and that after such study and consultation the recommended therapy should be approved by the Veterans Administration and the patient permitted to select a physician qualified to provide the treatment suggested."

MISCELLANEOUS BUSINESS

A communication from a local medical society on the matter of autopsies was discussed and referred to Committee on Public Relations and Economics for study and recommendations.

A communication from a member, regarding a chest x-ray program carried on under contract by a hospital, was considered. The file was referred to Dr. Hudson, councilor of the Fifth District for investigation and a report back to The Council.

A letter from a member protesting the regulation of the Veterans Administration regarding the ceiling of $6,000 per annum on fees paid to physicians was discussed. Attention was called to the fact that The Council is already on record as believing that this rule is undesirable, that a protest had been filed with the Veterans Administration, and that the Veterans Administration did not act favorably on the suggestion that the rule be rescinded.

A communication from a county medical society, stating that a motion had been adopted by that society to create a class of members to be known as junior members, was discussed. The Council instructed the executive secretary to write the society and advise it that the only way this matter could be handled by the society would be through an amendment to the constitution and by-laws of that society.

On **motion** duly made, seconded and unanimously **carried**, The Council authorized a contribution of $100 to the National Society for Medical Research.

A request from the Practical Nurses' Association that the Ohio State Medical Association name a representative to sit on its advisory committee was disposed of through the adoption of a motion authorizing the president to name such a representative.

A request from the Ohio State Radiological Society, that the Association name a special committee to consider questions arising between hospitals and physicians, was considered. The Council reaffirmed its previous action to the effect that such matters could be handled by either the Committee on Public Relations and Economics or the Judicial and Professional Relations Committee.

The Council was advised that Dr. John D. Porterfield, State Director of Health, had requested the Association to name a representative on an Advisory Committee on Poliomyelitis, which is being created by the department. The president was authorized to appoint a representative of the Association to serve on that committee.

APPROVE STATE CONFERENCE

At the suggestion of Dr. Paul I. Hoxworth, Cincinnati, president of the American Association of Blood Banks, The Council considered the idea of the Ohio State Medical Association sponsoring a state-wide conference of all individuals, groups and agencies interested in blood banks and blood donor programs for the purpose of working with cooperative and coordinated activities, especially activities which will play an important part in the national emergency. By official action, The Council approved the idea and instructed the executive secretary to work out the details with Dr. Hoxworth and others.

A number of letters from citizens in various parts of the state, expressing dissatisfaction with services received from physicians or fees charged by physicians were discussed. The executive secretary was instructed to refer these communications to the councilor of the areas involved so that a thorough investigation could be made by him in conjunction with the county medical societies and the physicians involved, and that the executive secretary follow this procedure in handling future cases of this kind.

Mr. Saville presented a number of sample cartoons on the general question of socialized medicine for the purpose of getting the reactions of members of The Council as to their desirability for distribution. The Council approved the general idea and instructed the Department of Public Relations to proceed with further planning for their production and distribution.

DR. BOWMAN RESIGNS

Dr. Swartz read to The Council a letter from Dr. J. Craig Bowman in which Dr. Bowman tendered his resignation as councilor of the Third District. On **motion** duly made, seconded and unanimously **carried**, The Council accepted the resignation with regret and expressed appreciation to Dr. Bowman for his conscientious and active work over a period of many years.

By unanimous vote, The Council elected Dr. Fred P. Berlin, Lima, to fill the vacancy on The Council created through the resignation of Dr. Bowman. Under this action Dr. Berlin will serve as Councilor of the Third District until the time of the 1951 Annual Meeting, April 24-26, when under the provisions of the Constitution and By-Laws, the House of Delegates will elect a successor to Dr. Bowman for his unexpired term, ending in the Spring of 1952.

There being no further business, The Council adjourned.

Attest: CHARLES S. NELSON,
Executive Secretary.

Ohio's Public Health Needs . . .

Committee on Public Health, Representing Twelve State-Wide Groups, Recommends Possible Improvements Throughout State in Final Report

NUMEROUS suggestions for improving the operation and services of local health departments in Ohio are set forth in a report issued in October by the Ohio Committee on Public Health and transmitted to the Ohio Director of Health, with a recommendation that follow-up action be taken by groups and organizations interested in strengthening the state's public health program.

The Ohio Committee on Public Health represents 12 state-wide organizations banded together for the purpose of evaluating tax supported public health services in the state, making recommendations for the improvement of these health services, and planning a program of action for the accomplishment of recommendations.

COMPOSITION OF COMMITTEE

These organizations are: The Ohio State Medical Association, The Ohio Farm Bureau Federation, The Ohio State Grange, The Ohio Congress of Industrial Organizations, The Ohio Federation of Labor, The Ohio Tuberculosis and Health Association, The Ohio Congress of Parents and Teachers, The Ohio State Veterinary Medical Association, The Ohio State Nurses Association, The Ohio Hospital Association, The Ohio Federation of Women's Clubs, and The Ohio Association of Township Clerks and Trustees.

The committee during 1948 completed a study of the Ohio Department of Health. The report of that study was presented in the pamphlet *Ohio Can Have Better Public Health Service.*

The report, just completed, concerns itself with the problems of local public health departments, their administration, their finances, their personnel and the services rendered by these departments to the people.

METHOD OF STUDY

Specifically, the committee:

Analyzed the organization of Ohio's local health departments and looked into the relationships of local units of government to the Ohio Department of Health.

Compared the various departments with recognized standards established by the American Public Health Association and the United States Public Health Service for the size of the district in terms of population and area.

Studied local health department finances—the sources of funds, the amount of money spent, the amount of money needed.

Investigated the service rendered by local health departments to see how they compare with accepted program standards promulgated by the American Public Health Association.

Inquired into the type training, and quality of present personnel, as well as the personnel needed by local health units to render the services expected by the citizens of the community.

FOLLOW-UP ACTION PROPOSED

In transmitting the report to State Director of Health J. D. Porterfield, the committee made the following comments:

"Although the committee as a whole believes that local public health services in Ohio can, and should, be improved, opinions of committee members differ as to exact method, or methods, for improving such services. Therefore, the committee has not attempted to set forth a single, arbitrary solution to the problem. Instead, it has set forth numerous suggestions, believing that some of them individually, or in some combination, might well be the basis for improved public health services in all areas of the state.

"With the issuance of this report, the Committee feels that it has accomplished the two objectives for which it was established: first, a study of the Ohio Department of Health, including recommendations for improving its efficiency and effectiveness and, second, a study of local public health services with suggestions for improving and strengthening such services.

"This committee is not, and was not intended to be, an action group. If follow-up action on any of the committee's suggestions is indicated, such action must come from individuals and permanent organizations throughout the state interested in this question.

"Therefore, the committee, prior to its dissolution, is transmitting to you copies of both reports for whatever use your department and the people of Ohio generally may care to make of them."

SUMMARY OF FINDINGS

Following is a summary of the committee's findings on local health units:

I. Organization—

A. There are too many separate health departments in Ohio. At the present time Ohio has 159 separate health departments. Many of the areas served by these depart-

ments are too small to maintain efficient adequate public health services. Of the 159 departments, 130 serve a population of less than 50,000 each. The area should have enough people and enough money to support a complete public health program.

B. Public Health programs need full time administration. Eighty-seven departments in the state employ part time health commissioners. It is essential to good service that all health commissioners be full time employees, spending their entire effort in planning and directing public health programs.

C. Competent, alert and interested boards of health are essential. A local health department cannot carry on its work effectively unless it has the backing and support of such a board. In some areas of the state, the board of health is composed of persons who are not qualified for such an important position. Some who have studied ways and means of correcting this situation believe that the procedure for selecting members of the board should be improved. They have offered suggestions as to how the procedure might be changed. There are others who believe that the present procedures are satisfactory. They suggest that efforts should be directed toward encouraging present appointing authorities to select better qualified and more interested persons for the boards of health. The arguments pro and con on this question are set forth in some detail in this report.

II. Finances—

A. Not enough money is appropriated for local public health in Ohio. The median per capita expenditure for local health service in Ohio is 48c a year. The minimum per capita annual expenditure recommended by the American Public Health Association and National Health Council is $1.50. A method of appropriating money locally should be devised which will make available sufficient funds for the operation of adequate local public health programs.

B. The method of distributing state subsidies does not encourage better public health services. State subsidy is paid to local health departments on a straight matching basis of 50c on the dollar spent for health commissioner, nurse and clerk to a maximum of two thousand dollars per year. Any subsidy should be based on needs and services.

III. Personnel—

Many local health departments have found it difficult to attract and hold minimum standard personnel.

A. Twenty health commissioners do not have medical degrees. There are 148 who have not had post graduate training in public health.

B. While all nurses are registered, only 46 per cent have had postgraduate training in public health.

C. Only 45 per cent of the public health sanitarians and sanitary engineers in local health departments have the basic qualifications established by the American Public Health Association.

D. Only three departments have health educators.

Better salaries, greater security, higher qualifications, and more intensive training programs are needed.

IV. Services—

This study does not attempt to evaluate services. It merely lists the minimum services required.

The report states that at present the average health department serves a population much smaller than is recommended and lists the following alternative suggestions for solving this problem:

The establishment of local health districts and the procedures of unification are provided in the Ohio General Code. Any reorganization must be made by the Legislature. The following are the possible changes which could be made to revise the basic public health law of Ohio as it relates to local health districts:

A. The county could be made the basic health unit with permissive clause for cooperative plans between counties as is now possible in Ohio General Code. The advantages of this system of organization for health districts are as follows:

1. Municipalities would be combined into single health departments with their suburban areas. This would result in uniform regulations and administrative policy be much less confusing, more economical and make possible more effective attack on the over-all health problems of the area served.

2. Populations of health districts would more nearly conform to accepted standards of size. The number of districts would be immediately reduced from 203 to 88. There would be only 55 districts with a population of less than 50,000 instead of the 130 presently existing. Whereas there are now 77 districts with a population of 10,000 or less, under this proposal no districts would be that small.

3. A broader taxing base would be available upon which the fiscal needs of the health department could be founded. At the present time each small district must finance its own health department personnel. With a larger district these individual resources could be

pooled to the over-all advantage of the entire unit.

The disadvantages of this plan are:

1. There would probably be strong opposition from some groups, possibly especially the larger municipalities and their suburban areas. Whether such opposition would endanger the passage of this type of legislation needs serious study.

B. **Make the county the health district with all municipalities included except those over 100,000 in population.** This plan would have the same general effect as the first but might solve the problem of political opposition. There are two disadvantages:

1. From the standpoint of public health administration, this method continues to divorce the city and its health problems from its suburban district and continues to foster the conflicts which result from such a program.

2. The main problem in preparing such a piece of legislation lies in the fact that in order to establish these cities as health districts and to finance health departments within them, it would be necessary to rewrite by amendment a larger number of sections of Ohio General Code dealing with municipalities.

C. **The law which establishes health districts might not be changed at all.** There would be no problem of securing a change in legislation. Although the present organization of local health districts is especially complex, these sections have been clarified by court action and legal opinion. Such a period of legal testing would be required should new legislation be adopted. If this program is adopted, there would have to be a very intensive educational program to secure voluntary combination of health districts into local health units large enough to support a complete health service. Although the educational process is of great value, the present permissive legislation for combination of local health departments has been on the statutes for some thirty years. During this time the number of health units has been reduced only from 203 to 159.

On the matter of improving the personnel of local boards of health and possible new methods for the selection of board members, the report offers the following alternative suggestions:

City Health Districts: The mayor is the ex-officio president of the board of health. He appoints its five members with the confirmation of city council. Each member is appointed for a five-year term of office and appointments are made so that one expires each year.

This method has met with varying success. In many instances we find a highly competent, alert and interested board. On the other hand, there are many city boards of health so sluggish in their service that it is practically impossible to secure a quorum for board meetings.

The main objections to this system of securing members of a board of health are that it is often open to political pressures and is not cushioned against partisan political battles. Also, the appointing authority is so highly centralized that it does not appear to be a democratic method for the selection of a board having such broad authority under the law.

General Health Districts: This district is made up of townships and villages in each county exclusive of the municipalities of 5,000 and over. The mayor of each village and the chairman of the trustees from each township form a district advisory council which appoints the board of health and hears its reports. This plan has the following advantages:

A. The board is chosen by representatives from every part of the district.

B. The members of the advisory council are elected officials and therefore represent the people in the appointment of the board of health.

C. This procedure protects the board from partisan political pressures.

The objections to this procedure are as follows:

A. The appointing authority is invested in such a large group so widely distributed throughout the county, that it is difficult for public to make its wishes known in order to effect changes in the board of health.

B. So little responsibility is placed on the advisory council with respect to health department, that there is apparent indifference to the appointment of members of the board of health. This has resulted in several unsatisfactory situations.

1. The board of health may be made up of people uninterested in public health programs.

2. The same individuals may be appointed again and again. Often they know little about public health when first appointed and do not grow in knowledge with service through the years.

3. The appointees to the board of health may think their chief responsibility is to ask for as little money for the health department as possible. This is often a reflection of the attitude of township trustees who think the health department consumes tax monies which might otherwise be under their control in the general fund of the township.

Recommendations: The procedure for appointing local boards of health has been set down in

the Ohio General Code, therefore, any reorganization must be made by a change in legislation. The following are posible methods for appointing local boards of health:

A. Appointment by the county commisioners. This method has three good features:

1. It centralizes the appointing authority into a small number of persons. When the group is small, responsibility is more concentrated.

2. Appointment by county commissioners buffers the board to some extent against partisan politics.

3. There is a precedent for appointment by county commisisoners. This procedure is now followed for appointing other boards who render services to the entire county.

This method of appointing local boards of health has two drawbacks.

1. The appointing authority is in the hands of a very few people. From the standpoint of concentrated effort, this is good. But it is easier for a small group to abuse its power.

2. Indigent medical care and welfare are under the commissioners. There might be pressure to bring the health department into these programs.

B. The board of health might be elected at a general election the same as is now done for a board of education. This method has two main features in its favor. First, it brings the board of health, its membership, responsibilities and duties, to the direct attention of the entire population. Here is an opportunity for public education which could not be secured in any other way. Second, the public choice of members of the board of health is a democratic procedure. The bad feature is this: boards of health are immediately opened to the partisan political pressures of a general election.

C. The present method of choosing the board of health may be left unchanged. The good and bad features of this method have been pointed out. In addition the present method does away with the need for a legislative battle that would follow a change in method.

Recommendations of the committee on the question of improved financing for local health departments are as follows:

Not enough money is spent for public health in Ohio. The median per capita expenditure for local health service in Ohio is 48 cents. The minimum per capita expenditure recommended by the American Public Health Association is $1.50. Local appropriations are restricted by the ten mill limitation on taxes. A method of appropriating money locally should be devised which will bring sufficient funds for the operation of local health programs. Recommendations are as follows:

A. Special millage. A special tax over and above the ten mill limit might be set aside for health purposes only. These funds would be granted directly to the health department and would be free from any political maneuvering in the budget commission which would divert the funds for any other use. This plan has an added advantage of providing a secure income so that each year the board could base its program on a fairly stable budget.

Inflexibility is the disadvantage. From the point of view of the board of health the millage might not increase with the need for expanded services and an expanded budget. From the point of view of the people, a special millage removes the necessity for the health board to justify its need for funds each year.

There is a danger that with a stable and independent budget, a department will tend to be lax in the service it provides. A modification of this plan might lessen this shortcoming to a certain extent. Under this plan the health department would submit its budget to the governing body, which would approve the total and have authority to levy within the special tax granted for health purposes. This is a more complex way of securing a budget and would require budgeting for health purposes a year in advance. Planning of long range programs is a good administrative technique. However, specific line-item budgets for a fiscal year, which is one year hence, poses extreme problems in sound budgeting and programming.

B. Appropriation from the county general fund. There are two advantages here:

1. Precedent has already been set to secure health funds from this source since tuberculosis care is already lodged with the county commissioners. Also the broader taxing base would have the general effect of making more money available for budgeting to health purposes and coordinate more closely tuberculosis central programs.

2. Securing funds from this source, in addition to making more money available for health work, also would require the board of health and its administration to justify its budget before responsible officials at the end of each fiscal period.

The disadvantages are:

1. Under existing laws health appropriation from the general fund is now allowed.

2. County commissioners are now charged with the care of welfare cases in terms of medical care. The county commissioners may tend to combine the public health program with medical care programs. This would create the very real danger of making a

local health department responsible for indigent medical care and other welfare programs.

C. Increase in the ten mill limit. This would be a specialized millage over and above the constitutional limit. The advantage is this:

1. Such a program would make possible an increase in the amount of money available for public health.

The disadvantage is this:

1. A general increase in the ten mill limitation on funds would certainly meet very strong opposition since it might lead to increased governmental costs from all departments.

D. Leave financing as it is now done. Advantage is it requires no legislative change.

State subsidies are too low and are not distributed according to local needs, the report points out. It presents the following recommendations for distribution of the state subsidy to local health departments:

RECOMMENDATIONS

State subsidy should possess these general qualities:

A. The method of distribution should be simple so that every person can understand its operation.

B. It should be elastic enough to apply to all health districts in the state.

C. It should be designed to equalize health services so that poorer areas are given greater assistance.

A formula for state subsidy might contain these provisions:

A. The department must meet minimum standards of eligibility in order to receive the subsidy.

B. State funds should not be substituted for local money in developing the program.

C. A sliding scale of distribution, depending upon population and wealth, should be developed according to local resources to equalize the amounts given.

D. Minimum standards of service should be met for a district to continue to be eligible for the grant.

With respect to personnel problems confronting local health units, the committee commented as follows:

Not enough personnel is employed by local health departments to carry out a well organized health program. Too few employees have had the opportunity to secure postgraduate training in their field. Salaries are not in keeping with the responsibility placed on employees nor equal to average paid to employees occupying similar positions in other states.

Cancer Meeting Sponsored in Columbus, November 19

The Committee on Cancer of the Ohio State Medical Association and the Ohio Division of the American Cancer Society are sponsoring a meeting to be held at the Neil House in Columbus, on Sunday, November 19, beginning at 10 a. m.

Special invitations are directed to District Councilors of the Ohio State Medical Association, members of medical advisory committees appointed by County Medical Societies, medical trustees of the Ohio Division, officers of County Medical Societies and any other interested physicians.

Principal scientific speakers for the occasion will be Dr. Charles S. Cameron, head of the Medical and Scientific Department of the American Cancer Society, who recently returned from the Fifth International Cancer Congress in Paris, France; and Dr. Alton Ochsner, president of the American Cancer Society, dean of the Medical School of Tulane University and head of Ochsner Clinic of New Orleans.

Officials of the Society announced that the American Cancer Society would underwrite expenses of those who attend. The meeting is scheduled to adjourn following luncheon.

Fellowships in Industrial Health Offered at Cincinnati

The Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of Fellowships which are being offered to qualified candidates who wish to pursue a graduate course of instruction which will qualify them for the practice of Industrial Medicine.

Candidates who complete satisfactorily the course of study will be awarded the degree Doctor of Industrial Medicine. Any registered physician, who is a graduate of a Class A medical school and who has completed satisfactorily two years of residency (including internship) in a hospital accredited by the American Medical Association may apply for a Fellowship in the Institute of Industrial Health.

The course of instruction consists of a two-year period of intense preliminary training in the basic phases of Industrial Medicine followed by one year of practical experience under adequate supervision in industry. During the first two years, the stipends for the Fellowships vary from $2,100 to $3,000. In the third year the candidate will be compensated for his service by the industry in which he is completing his training.

Requests for additional information should be addressed to the Institute of Industrial Medicine, College of Medicine, Cincinnati 19, Ohio.

St. Luke's Hospital, Cleveland, Continues Weekly Symposia

Saint Luke's Hospital, 11311 Shaker Blvd., Cleveland, announced continuation of its weekly symposia as follows:

Wednesday, November 1—Sequelae of Subdural Hematoma.

"Clinical Aspect," Dr. J. H. Nichols, St. Luke's and Western Reserve University School of Medicine.

"Pathological Aspect," Dr. Rafael Dominguez. St. Luke's and Western Reserve.

"Rehabilitation of Hemiplegia," Dr. Clark Randt, Crile General Hospital and Western Reserve.

"Convulsive Disorders and Treatment," Dr. C. J. Centa, St. Luke's.

Wednesday, November 8—Backache.

"An Outline of the Types and Causes of Backache," Dr. W. S. Duncan, St. Luke's.

"An Examination of the Back with Diagnostic Signs and Symptoms," Dr. W. H. McGaw, St. Luke's and Western Reserve.

"The Gynecological and Obstetrical Aspects of Backache," Dr. G. B. Hurd, St. Luke's.

"The Neurosurgical Aspects of Tumor or Ruptured Intervertebral Disc," Dr. Spencer Braden, St. Luke's.

"The Conservative Treatment"—Demonstration of Strapping, Braces, etc., Dr. J. E. Brown; Demonstration of Exercises and Manipulations, Dr. S. G. Stubbins; The Choice of Various Types of Heat, Dr. W. M. Solomon.

"The Indications for Surgical Orthopedic Treatment of the Painful Back," Dr. T. A. Willis, St. Luke's.

Wednesday, November 15—The Kidney.

"Biochemical Tests of Renal Insufficiency as a Guide to Therapy," Dr. Frank S. Houser, St. Luke's.

"The Recovery Phase of Acute Renal Block," Dr. Rafael Dominguez, St. Luke's and Western Reserve.

"Urinary Obstruction in Infancy," Dr. D. W. McIntyre, St. Luke's.

"Management of Urinary Infection," Dr. D. A. Chambers, St. Luke's and Western Reserve.

Wednesday, November 29—Allergy in Children.

"Technique of Testing Methods," Dr. McKinley London, St. Luke's.

"Asthma and Hayfever," Dr. A. J. Horesh, Western Reserve.

"Effect of Allergies on the Whole Child," Dr. Ralph I. Fried, St. Luke's.

"Pathological Aspects of Allergy," Dr. Rafael Dominguez, St. Luke's and Western Reserve.

"Dermatologic Allergy; Gastrointestinal Allergy," Dr. Fred Rittinger, Head of the Department of Pediatrics, Saint Luke's Hospital.

Wednesday, December 6—Occupational Hazards.

"Various Hazards with Particular Reference to Toxic Solvents and Lead," Dr. Allen J. Fleming, assistant medical director, E. I. duPont de Nemours & Co., and formerly assistant director, Haskell Laboratory of Industrial Toxicology.

"Silicosis," Dr. R. C. McKay, Western Reserve and Cleveland City Hospital.

"Toxicity of Beryllium," Dr. A. D. Nichol, St. Luke's.

Many County Fairs Covered by Association's Exhibits

Nearly every week of the 1950 county fair season found exhibits from the Ohio State Medical Association on display in one or more locations in the state.

See Photos on Facing Page

During the season there were two exhibits available for use by the county societies or their auxiliaries who sponsored booths at their county fairs or other community celebrations. They covered, in simple, understandable language brucellosis and the progress in medical science made during the past century.

At the Miami county fair, the Auxiliary to the Miami County Medical Society sponsored the Progress-In-Medicine exhibit, which was displayed in a building set aside for health exhibits. Various members of the auxiliary staffed the exhibit and handed out thousands of pieces of literature covering the exhibit and other health-interest subjects. The Brucellosis display was a high-light of the Vinton County Centennial Celebration held this summer at McArthur. Dr. Herbert Chamberlain, who was one of the guiding lights of the celebration, supervised the medical display.

In Trumbull County the County Medical Society sponsored a booth which included among other displays, the Progress exhibit. In a booth located under the grandstand, thousands of northeast Ohioans studied the exhibits and received informative literature.

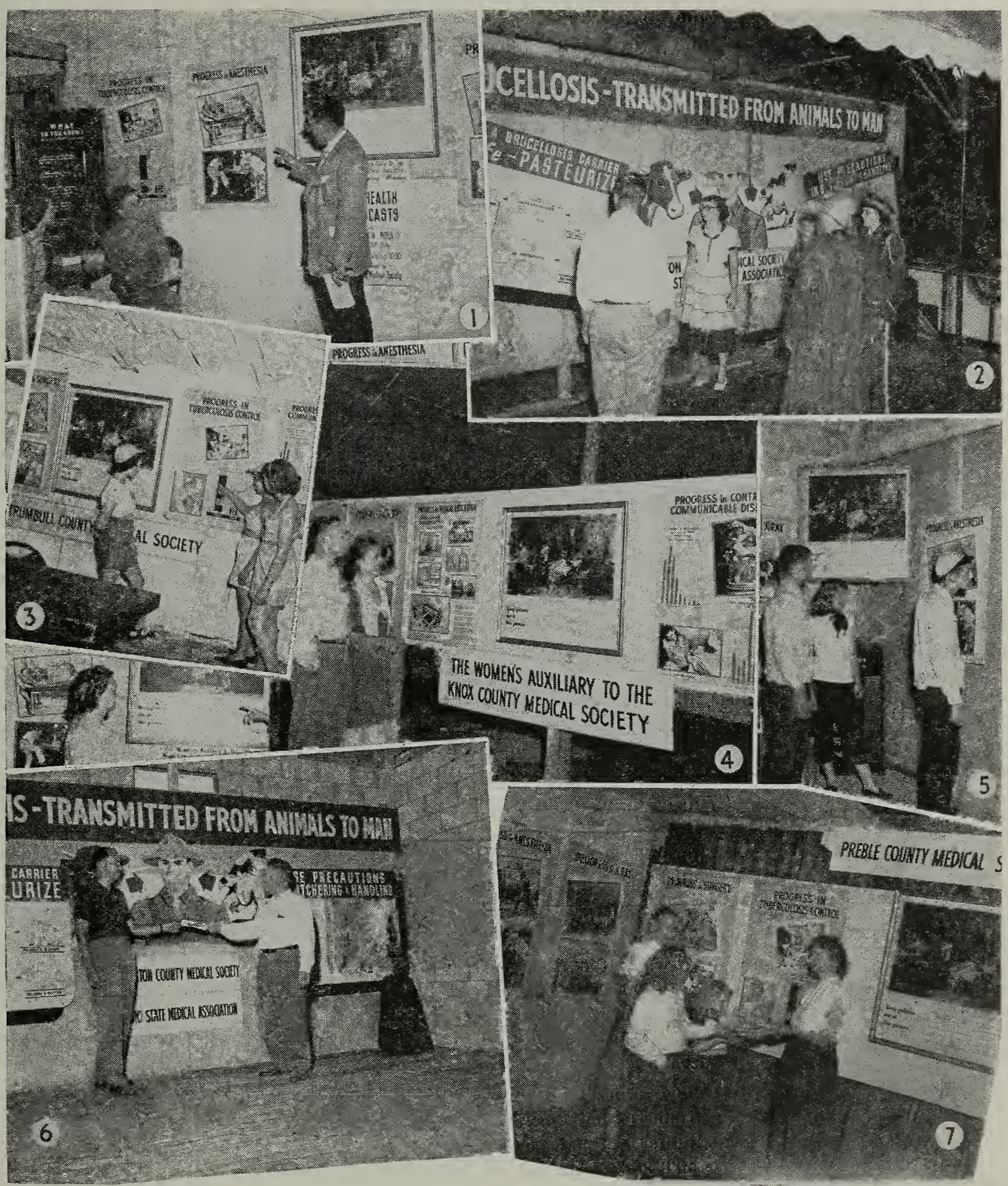
In Columbiana County and Knox County the fairs were held at St. Clairsville and Mt. Vernon respectively, and both exhibits were sponsored by the Auxiliaries.

In Preble County the ladies staffed their booth, which featured the Progress display as well as a display boosting *Today's Health*.

The Clinton County Medical Society presented the Brucellosis exhibit at their county fair at Wilmington.

Instrumental in installing and helping to man the exhibits, were Mr. Hart F. Page and Mr. Russell C. Mock, of the Association's Public Relations Department.

Association Promotes Health at County Fairs



O. S. M. A. Staff Photos

These are candid shots of some of the exhibits sponsored by the Public Relations Department of the Ohio State Medical Association at county fairs this season

(1) Dr. George Woodhouse explains points of the Progress-In-Medicine display at the Miami County Fair while Mrs. Woodhouse and Mrs. William Trostel look on.

(2) Visitors to the Vinton County Centennial Celebration look over the Brucellosis exhibit.

(3) Three youngsters looking over the many posters depicting the last 100 years' progress in medical science on display at Warren in Trumbull County during the county fair.

(4) Mrs. John L. Baube explains the exhibit to a visitor to the Knox County Auxiliary's display at the county fair.

(5) A group of three high-schoolers study the display sponsored by the Auxiliary to the Columbiana County Medical Society at the Columbiana Fair, St. Clairsville.

(6) Dr. Edmond K. Yantes, of Wilmington, is shown with a Clinton County man looking at the Brucellosis exhibit.

(7) Mrs. Birna R. Smith and Mrs. E. P. Trittschuh of Preble County, hand out literature to young visitors during the first day of the Preble County Fair.

(See article on facing page.)

A.M.A. Cleveland Meeting . . .

Elaborate Plans Are Laid by Local Committees for Mid-Year Session, December 5-8; Diversified Program Is Arranged for All Practitioners

ELABORATE planning, especially by a large Cleveland Committee, is shaping up a program that promises one of the most thorough Interim Sessions of the American Medical Association in Cleveland, December 5-8.

The Council on Scientific Assembly of the A. M. A. headed by Dr. Henry R. Viets, of Boston, met with state and local representatives in Cleveland on September 20 and laid final plans.

A complete program of the scientific meeting will appear in a forthcoming issue of *The Journal of the A. M. A.* Here is just a resumé of topics to be discussed:

Hemorrhagic Diseases, Cancer, Cardiovascular Diseases, Diabetes, Obstetrics, Pediatrics, Dermatology and Syphilology, Gastrointestinal Diseases, Traumatic Surgery, ACTH and Cortisone, Anesthesia, Medical Therapy, Neurology and Psychiatry, Ectopic Pregnancy, Poliomyelitis, Fluid Balance, Parenteral Protein Feeding, Fractures in the Age of Antibiotics.

On most of the foregoing subjects, several sessions have been arranged to permit doctors a wide schedule of choice.

An elaborate program of television sessions has been arranged with surgery lectures from Western Reserve University School of Medicine. All scientific sessions have been arranged primarily with the general practitioner in mind.

LOCAL COMMITTEES

Dr. Fay A. LeFevre, of Cleveland, is chairman of the local Administrative Committee, with the following other members, all of Cleveland: Dr. Fred W. Dixon, President-Elect of the Ohio State Medical Association; Dr. A. Carlton Ernstene, Dr. Farrell T. Gallagher, Dr. Donald M. Glover, Dr. Charles L. Hudson, Councilor of the Fifth District, Dr. Edward F. Kieger and Dr. Herbert B. Wright.

Chairman of other committees are: Subcommittee on General Meeting, Dr. Howard Diettrick, Subcommittee on Information and Registration, Dr. Leonard L. Lovshin; Subcommittee on Exhibits, Dr. David Kirk Spitler; Subcommittee on Housing, Dr. Irdell M. Hinnant; Subcommittee on Television Program, Dr. William D. Holden.

Chairman of Scientific Program Subcommittees are the following: Anesthesia, Dr. R. J. Whitacre; Cancer, Dr. William F. Boukalik; Cardiovascular Diseases, Dr. A. Carlton Ernstene; Dermatology and Syphilology, Dr. George W. Binkley; Diabetes, Dr. Edmund E. Beard; Fluid Balance, Dr. Chester R. Lulenski; Gastrointestinal Diseases, Dr. E. N. Collins; Medical Therapy, Dr. Stanley M. Goldhamer; Neurology and Psychiatry, Dr. Douglas Bond; Obstetrics, Dr. Clifford J. Vogt; Pediatrics, Dr. Charles F. McKhann; Poliomyelitis, Dr. Walter M. Solomon; Traumatic Surgery, Dr. Donald M. Glover.

Attending the September meeting also were Dr. George F. Lull, Secretary and Manager of the A. M. A.; Dr. Austin Smith, Editor of the *Journal of the A. M. A.;* Dr. E. O. Swartz, Cincinnati, President of the Ohio State Medical Association, and Mr. Charles S. Nelson, Executive Secretary of the O. S. M. A.

Blanks for making hotel reservations may be found in current issues of the *Journal of the A. M. A.*

Features of the Session will be meetings of the House of Delegates.

Ohio Radiologists To Meet in Columbus, May 26-27

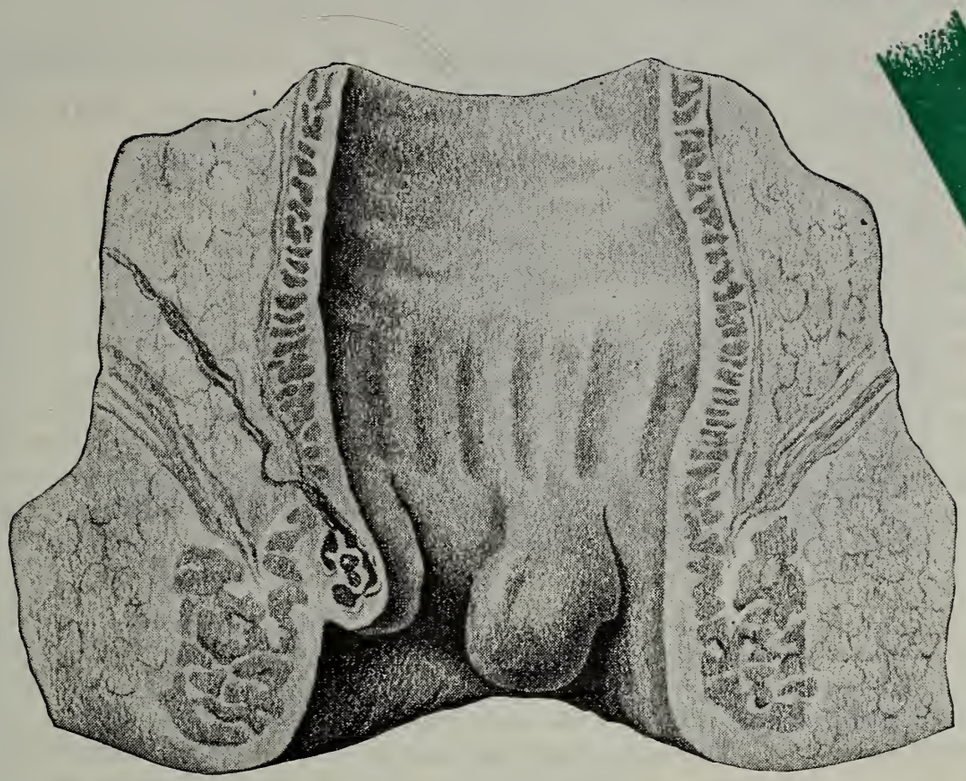
The annual meeting of the Ohio State Radiological Society will be held at the Fort Hayes Hotel, Columbus, on Saturday and Sunday, May 26 and 27, 1951.

Scientific sessions as well as business sessions will be held on both Saturday and Sunday. Golf will be played on Friday afternoon preceding the meeting, with the ladies participating if they wish. Following golf, dinner will be served. On Saturday evening, May 26, a gala affair is planned with dinner, entertainment and dancing.

One of the main purposes of the meeting will be to take advantage of the accomplishments of Ohio radiologists, officers announced. The meeting also will afford opportunity for Ohio radiologists to become better acquainted, they said.

A program has been arranged for the ladies. President of the Society is Dr. Arnold D. Piatt, of Newark.

The American Dermatological Association is offering a prize of $300 for the best essay submitted of original work relative to some fundamental aspect of dermatology or syphilology. The deadline is February 1, 1950. Further information may be obtained from Dr. Louis A. Brunsting, Secretary, 102-110 Second Ave., SW., Rochester, Minn.



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Doctors and the War . . .

Rules on Classification of Physicians Registered Oct. 16; Dr. Conard Named to Head Advisory Committee; Needs of Armed Forces Analyzed

NEW developments on the matter of providing medical officers for the armed forces as a part of the national preparedness program were as follows as this issue of *The Journal* went to press:

1. The Department of Defense has requested Selective Service to furnish a total of 922 doctors of medicine, 500 dentists and 100 veterinarians for the Army Medical Corps which needs approximately 1,325 medical officers to meet its immediate requirements.

2. First registration of male physicians under the Doctor Draft Act (Public Law 779) was held on October 16.

3. Local Selective Service Boards are in the process of classifying physicians who registered on Oct. 16; schedules for physical examination of those classified as available for induction will be announced soon.

4. No date set as yet by National Selective Service Headquarters for the registration of other male physicians under 50 years of age but who were not required to register on October 16.

5. Dr. Robert Conard, chairman, Military Advisory Committee of Ohio State Medical Association, has been appointed chairman of Ohio Advisory Committee to Selective Service by the Medical Advisory Committee of National Security Resources Board which is serving as advisor to National Selective Service.

6. Secretary of Defense Marshall directed the Navy to call V-12 medical reserve officers without prior service to active duty for assignment to the Army Medical Corps.

ARMY ASKS FOR INDUCTEES

In its memorandum asking Selective Service for physicians, dentists and veterinarians for the Army, the Department of Defense specified induction quotas as follows: 300 doctors of medicine by November 15; 300 doctors of medicine, 300 doctors of dental surgery or doctors of medical dentistry, and 50 doctors of veterinary medicine by December 15; 322 medical doctors, 200 doctors of dental surgery or medical dentistry, and 50 doctors of veterinary medicine by January 15.

The Department of the Navy and the Department of the Air Force have indicated that present plans do not call for submission of requisitions in these categories.

REGISTRATION ON OCT. 16

Male physicians who were required to register on October 16 were those comprising the first two priority groups specified in the Doctors' Draft Act (Public Law 779) namely: A. S. T. P. and V - 12 students and those deferred from active military duty in World War II to continue their professional education who had less than 21 months of active service in the armed forces or U. S. Public Health Service after completing their professional education and who are not at present in a reserve component of the armed forces. Physicians in these categories with more than 21 months of active service with the armed forces or U. S. Public Health Service and who are in good standing in some armed force reserve unit did not have to register on October 16.

Memoranda issued by Selective Service covered the following special situations:

SPECIAL INSTRUCTIONS

Male persons who on or after October 17, 1950, receive degrees in medicine, dentistry, etc., will be required to register **within five days of receipt of degree.**

Physicians between the ages of 18 and 26 who had registered in the general draft were required to register again under this special draft. His original local board will have jurisdiction over him.

Men were held individually responsible for locating the "duly designated registration official of Selective Service local board having jurisdiction in the area in which he has his permanent home or in which he may happen to be on that day." Anyone prevented from registering on the appropriate date because of circumstances beyond his control must register as **soon as possible** after cause of such inability ceases to exist.

Men absent from the country on their registration date are required to register **within five days** after their return.

Volunteers among physicians classified available by Selective Service but who enter the armed forces prior to induction will be counted against the Selective Service quotas.

Physicians who registered on October 16 were required to give only a minimum amount of information. Forms for detailed information were given to each with instructions to fill out the forms and return them to the local board within five days. A registration certificate (SSS Form No. 2) will be mailed by the board to the registrant after the completed forms are received.

CLASSIFICATION STARTED

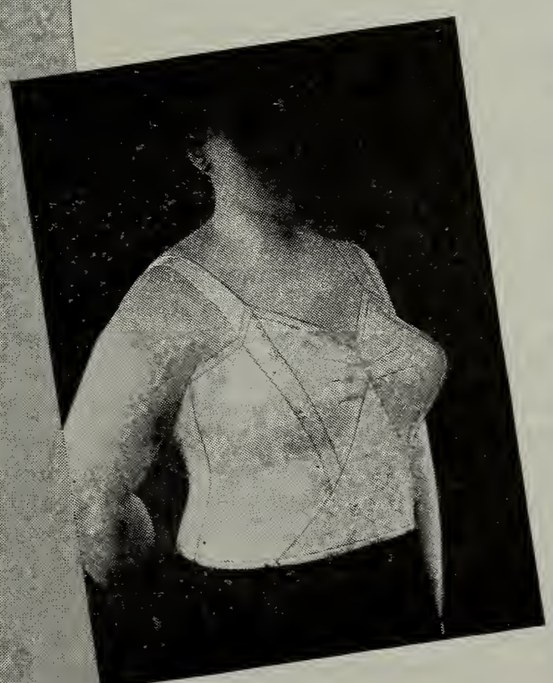
Local Selective Service Boards began the classification of physician registrants on Octo-

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ber 23. Classification is to be completed before November 15 if possible.

On November 15 local boards are expected to begin scheduling physicians classified as available for active duty for physical examinations so that all examinations for those put into Class I-A can be completed by Dec. 15.

CLASSIFICATION REGULATIONS

Following are classification regulations established by Selective Service governing physicians subject to the Doctors' Draft Act, not only those who registered on October 16 but others 50 years of age or under who will be required to register at some future date before January 16 —the date has not been set:

Each special registrant who has not attained the fifty-first anniversary of the day of his birth shall be considered by the local board as available for military service and eligible for classification in Class I-A until his eligibility for a deferred or exempt classification is clearly established to the satisfaction of the local board.

(Editor's Note: Although only those under 50 will be required to register, a registrant is liable for induction until he reaches 51.)

The delivery to a special registrant of a Classification Questionnaire (SSS Form No. 100) and an Initial Data For Classification and Commissioning in Medical Services For Medical, Dental and Veterinary Corps (DD Form No. 390) shall be notice to the registrant that unless information is presented to the local board, within the time specified for the return of the questionnaire and initial data form, which will justify a deferred or exempt classification, the registrant will be classified in Class I-A.

DEFERMENT CATEGORIES

Every special registrant shall be placed in Class I-A except that when grounds are established to place such registrant in one or more of the classes in the following table, the special registrant shall be classified in the lowest class for which he is determined to be eligible, with Class I-A-O considered the highest class and Class I-C considered the lowest class according to the following table:

Class: I-A-O
IV-E
I-D
II-A
III-A
IV-A
IV-F
V-A
I-C

A special registrant shall be placed in Class I-A-O if he is a conscientious objector but with no objection to non-combatant duty only.

A special registrant shall be placed in Class I-C if (1) he is on, or enters upon, active duty in the armed forces, or (2) he has entered upon active duty in the armed forces after the date fixed for his registration in any special registration and has been separated therefrom by honorable discharge or discharge under honorable conditions or by an equivalent type of release from service.

A special registrant shall be placed in Class I-D if he is or becomes a member of a reserve component of the armed forces.

ESSENTIAL TO COMMUNITY

A special registrant shall be placed in Class II-A only if it is determined that (1) the medical, dental, or allied specialist service being performed by such registrant in his community is necessary to the maintenance of the national health, safety or interest, (2) the service performed by him cannot be performed by other medical, dental, or allied specialists who are in the community, and (3) the registrant cannot be replaced in the community by another person who can perform such medical, dental or allied specialist service. It is the intent of these criteria that a special registrant shall be placed in Class II-A when his induction would cause the availability of essential health services to fall below reasonable minimum standards. In making such determination, the local board shall give consideration to but shall not be bound by any advice offered by the state and county advisory committees established by medical societies.

A special registrant shall be placed in Class III-A only if (1) it is determined that his induction into the armed forces would result in extreme hardship and privation to a wife,

Registration Date for Other Doctors Under 50 Has Not Been Set

Only a part of Ohio physicians who will be subject to the Doctors' Draft Act were required to register on Oct. 16.

Between now and Jan. 16, the Selective Service Director will set a Registration Day for those who were not in priorities Nos. 1 and 2—those who registered on Oct. 16.

At the time of the next registration all other male physicians who are under 50 years of age at that time will be expected to register.

These physicians comprise priority groups Nos. 3 and 4. Group 3 consists of those who did not have active service in the armed forces or U. S. Public Health Service after September 16, 1940. Group 4 consists of all other physicians under 50 years of age regardless of the amount of service after September 16, 1940.

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child, or parent, with whom he maintains a bona fide family relationship in their home, regardless of the date on which such bona fide family relationship was established, and (2) by reason of such determination it is considered advisable that he be deferred. The term "child" as used in this paragraph means a legitimate or an illegitimate child from the date of its conception, a child legally adopted, a stepchild, a foster child, and a person who is supported in good faith by the registrant in a relationship similar to that of parent and child, but shall not include any person 18 years of age or over unless he is physically or mentally handicapped.

OTHER REASONS

A special registrant shall be placed in Class IV-A only if he is the sole surviving son of a family of which one or more sons or daughters were killed in action or died in line of duty while serving in the armed forces of the United States, or subsequently died as a result of injuries received or disease incurred during such service.

A special registrant shall be placed in Class IV-E if he is a conscientious objector with objection to any duty with the armed forces.

A special registrant shall be placed in Class IV-F if he is found physically, mentally or morally unfit for military service.

A special registrant shall be placed in Class V-A if he has attained the fifty-first anniversary of the day of his birth after registering unless he is on active military service in the armed forces and is in Class I-C.

SPECIAL SITUATIONS

In classifying physicians local Selective Service Boards are directed to consider them in the sequence of their dates of birth with the youngest being considered first within each of the established categories.

Physicians classified in I-A will be called up for induction pursuant to special calls or requisitions filed with the National Director of Selective Service by the Department of Defense. These calls will be filled by states and by local boards on a quota basis. All such special calls must be made at least 60 days prior to the proposed date of induction. At least 21-days notice must be given to each physician scheduled for induction.

Any physician classified as I-A who obtains a commission voluntarily in the medical corps of one of the branches of the armed services prior to being notified to report for induction will not be inducted.

Physicians who are inducted will be inducted as privates and will in all probability be required to take a certain amount of basic training pending transfer to and commissioning in the medical corps of one of the branches of the armed forces.

Questionnaires To Obtain Vital Data Being Sent Out

In order to obtain very important data for its responsibility in advising the military and Selective Service on the medical needs of local communities, hospitals, medical schools, etc., and at the same time advise on the availability of physicians for service with the armed forces, the Military Advisory Committee of the Ohio State Medical Association is sending out three sets of questionnaires.

A questionnaire has been sent to Ohio hospitals asking them for information regarding their interns and residents.

The deans of Ohio's three medical schools have been requested to supply information regarding their faculties.

A third questionnaire is now being prepared to obtain biographical and professional data on every doctor of medicine in Ohio. It will be mailed out in the near future.

These data will bring the records of the Columbus Office up to date. It will be indispensable to the Military Advisory Committee in deciding situations in all areas and in various institutions.

The committee urges the fullest cooperation on the part of the hospitals, medical schools and individual physicians in getting the data to the Columbus office promptly.

ADVISORY COMMITTEES

Shortly after President Truman issued his proclamation setting October 16 as registration day for priority groups No. 1 and No. 2, he issued an executive order establishing a National Advisory Committee on the Selection of Doctors, Dentists and Allied Specialists.

This national advisory committee, although the members were named individually, is the same as the formerly-established Health Resources Advisory Committee of the National Security Resources Board.

Personnel of the national advisory committee is: Dr. Howard A. Rusk, New York City, chairman; Dr. James C. Sargent and Dr. Harold S. Diehl, of the A. M. A. Committee on Emergency Medical Services; Dr. Leo J. Schoeny, American Dental Association; Dr. William P. Shepard, professor of public health, Stanford University; Dr. John Pastore, New York hospital executive; and Mrs. Ruth Kuehn, dean of nursing, University of Pittsburgh.

Dr. Rusk, chairman of the national committee,

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Gray, L.: J. Clin. Endocrinol. 3:92 (Feb.) 1943.

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immediately appointed a chairman for a volunteer advisory committee in each state and certain others to serve with him.

DR. CONARD OHIO CHAIRMAN

Dr. Robert Conard, chairman of the Military Advisory Committee of the Ohio State Medical Association, was appointed chairman of the Ohio advisory committee. Those named to serve with him temporarily were: Dr. John D. Porterfield, Ohio director of Health, and Dr. J. C. Longfellow, Bellefontaine, dentist.

Dr. Conard, Ohio chairman, may appoint, subject to confirmation by the national committee, such additional members of the state committee as may be necessary to carry out its functions. This is now under consideration by Dr. Conard.

The state advisory committee may appoint at state and local levels such separate subcommittees of physicians, dentists and veterinarians as may be deemed necessary to give appropriate consideration to the respective needs of the armed forces and of the civilian population.

WILL USE OSMA COMMITTEE

As a sub-committee on physicians Dr. Conard will use the Military Advisory Committee of the Ohio State Medical Association of which he is chairman. As local committees, Dr. Conard plans to use the Military Advisory Committees being established by the state's 88 county medical societies.

The Ohio Veterinary Medical Association has a committee similar to that of the Ohio State Medical Association and that committee undoubtedly will be designated as a sub-committee on veterinarians for the State Advisory Committee.

Plans for setting up sub-committees for dentists and for public health personnel are under consideration.

Personnel of the Military Advisory Committee of the Ohio State Medical Association, which will serve for the Association in cooperation with County Medical Society military advisory committees and assist Dr. Conard on his other assignment as well, is as follows:

First District: Dr. David A. Tucker, Jr., Cincinnati; **Second District:** Dr. Homer D. Cassel, Dayton; **Third District:** Dr. Lester C. Thomas, Lima; **Fourth District:** Dr. A. A. Brindley, Toledo; **Fifth District:** Dr. Donald M. Glover, Cleveland; **Sixth District:** Dr. Ralph L. Rutledge, Alliance; **Seventh District:** Dr. Albert E. Winston, Steubenville; **Eighth District:** Dr. Walter L. Cruise, Zanesville; **Ninth District:** Dr. C. L. Pitcher, Portsmouth; **Tenth District:** Dr. E. L. Montgomery, Circleville; **Eleventh District:** Dr. Charles R. Keller, Mansfield.

FUNCTIONS OF ADVISORY GROUPS

In performance of their duties the National, state and local advisory committees are to give appropriate consideration to the needs of the armed forces and of the civilian population for the services of medical, dental and allied professional personnel. The state and local advisory committees are expected to establish and maintain liaison with the State Selective Service Director and with local Selective Service Boards for the purpose of advising them on the classification of physicians, dentists, etc.

National Selective Service Director Lewis B. Hershey in a directive dated October 13 pointed out that the state and local committees are not

Must Have Advisory Committee In Each County Immediately

In a statement released to The Journal, Dr. Robert Conard, chairman of the Military Advisory Committee of the Ohio State Medical Association and who is on full-time duty in the Columbus Office of the Association, urged all County Medical Societies to immediately set up local Military Advisory Committees if they have not already done so and to send the names of committee personnel to the Columbus Office.

"It is vital that we have a strong Military Advisory Committee in each county," Dr. Conard said. "These local committees will be expected to establish a close working relationship with local Selective Service Boards. If this is done, an equitable distribution of physicians between civilian needs and military demands can be worked out.

"Local boards and local committees may not always agree on the classification of physicians, or they may agree too readily on an unsound solution. When such situations arise, the member of the State Military Committee representing the area will be alerted. He will be expected to evaluate the situation, obtain facts, etc., and bring the matter to the attention of the state committee for study and recommendation. The state committee can then present the arguments to the State Director of Selective Service and even to the National Advisory Committee to Selective Service."

Dr. Conard pointed out that the state committee must depend on local committees to secure basic facts and data and to enter into initial discussions with Selective Service through the local board or boards. The state committee will be expected to act as an appellate body and to intervene only in cases where no agreement on a local basis can be reached, he said.

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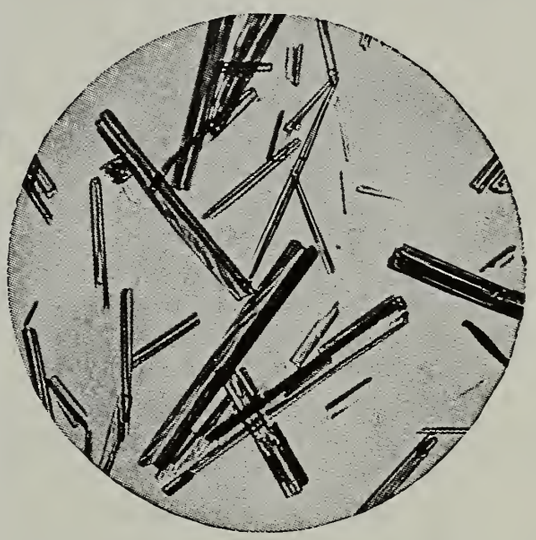
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a part of the Selective Service System but volunteer advisory committees. He emphasized however that State Directors of Selective Service and local Selective Service boards are to "effect full cooperation with the volunteer advisory committees."

ARMY SHORTAGE ACUTE

Here are developments leading to the Army's request to Selective Service:

Secretary of Defense Marshall on September 29 directed the Navy to immediately order to active duty enough V-12 reserves without prior service to meet requirements of all three military departments—Army and Air Force as well as the Navy. An announcement from the Department of Defense stated that the Army had requested the Navy to assign 570 of these reserves to it—the first increment of 235 to report to duty by October 15.

The announcement further stated that of the 1,429 Navy reserve medical officers in priority group one, some 1,350 were at that time available for immediate call to active duty. The remainder were members of Organized Reserve units not subject to call at this time. The Army, according to the same release, was calling to active duty some Army medical reserve officers in certain grades and specialties.

NEED SOME RESERVE OFFICERS

The Army has an immediate shortage of 1,325 physicians. To meet this a limited number of World War II physicians are being called involuntarily from the reserves. Reserve medical officers assigned to Organized Reserve Corps units will be called to duty as their units are brought into active service. The professional complements of the larger medical units will not be called for initial training phases.

The 570 V-12 physicians requested of the Navy will be detailed to the Army to meet current critical requirements.

As soon as there are additional volunteers or Selective Service starts meeting Army requirements, Navy personnel will be returned to that service and involuntarily recalled Reserve officers will be released, except those in the higher grades being utilized as specialists and in senior command assignments. "Specialists cannot be released unless Public Law 779 (Doctor-Draft Law) provides replacements for them," the Army release states.

Army requirements will be 3,200 physicians to meet current expansion plans, it is said.

REASONS FOR VOLUNTEERING

The Army newsletter enumerated these reasons why it is to the advantage of registrants to volunteer rather than be drafted:

First, volunteers will receive an additional $100 per month professional pay;

Second, those who volunteer and are commissioned need not register. (The letter was issued before the October 16 registration.)

Third, professional skills can be utilized better than under Selective Service, which makes only bulk numbers of physicians available without classification.

Quick Way To Obtain Commission Announced By the Army

Physicians who registered with Selective Service on October 16 and who are classified as 1-A (available for military service) will be given an opportunity to secure a commission in the Army Medical Corps Reserve without delay and red tape under a speed-up procedure for commissioning medical officers just announced by the Department of the Army.

If a physician 1-A registrant is found physically and professionally acceptable to the Army (which is the only branch of the armed forces that has asked Selective Service for medical officers to date) and he has indicated on his registration blank that he desires a commission, the Army will offer him a commission and will notify him to appear before a notary public to execute the oath of office. He will be asked at a later date to complete necessary papers for the Army records.

Once the oath is administered, the physician becomes a member of the Army Medical Corps Reserve and is no longer subject to induction by Selective Service.

When the physician notifies his local Selective Service Board that he has taken the oath of office and is therefore commissioned, the board removes his name from its roster. It credits his name against the quota of physicians that Ohio is expected to furnish to the Army.

Physicians commissioned in this manner will be called to active duty by the Army after consultation with the Military Advisory Committee of the Ohio State Medical Association.

Physicians who are classified by Selective Association who are classified by Selective Service as 1-A and found acceptable for military service but do not obtain a commission in the manner described above, or through regular channels, will be subject to induction as privates. If inducted they undoubtedly would have to serve some basic training before being commissioned. Physicians commissioned from the ranks after induction will not be entitled to the extra $100-per-month pay allowed physicians who enter the service as commissioned officers.

Eligibility for Local Health Aid . . .

Statement of Policy Is Issued by Health Director Outlining Minimum Standards for Maximum Services; List of Qualified Units Is Given

TO clarify existing policy which governs distribution of field services to local health units, Dr. John D. Porterfield, director of the Ohio Department of Health, has issued a statement to all Ohio health commissioners.

The explanation came as the Ohio Department of Health is consolidating its field consulting personnel into district offices, as previously announced. The five district field offices are as follows: Southeast District, Athens; Northeast District, Cuyahoga Falls; Northwest District, Bowling Green; Central District, Delaware; Southwest District, Dayton.

If a local health department meets certain specified standards it is eligible for the maximum services and aids offered by and through the State Department. If it does not meet those standards, it is still eligible for certain services.

MINIMUM STANDARDS

If the local health department meets these minimum standards—(a) full-time health commissioner, nurse, sanitarian and clerk, paid from local funds; (b) an office open during the normal work week prevailing in the community; and (c) a program which offers the seven basic services of local health to the community—it is eligible for the following services:

1. All legal responsibilities placed on the Ohio Department of Health by state statute such as public and semi-public water and sewage supply supervision.
2. All emergency services in either epidemic or community disaster.
3. All ancillary and specialized service programs such as tuberculosis and dental trailers, etc.
4. All consultative and advisory services which assist nursing, sanitation and clerical personnel in their local program.
5. Eligibility to participate in grants-in-aid program.

If a local department does not meet the foregoing minimum standards, it is eligible for the following services:

1. All legal responsibilities as indicated in the foregoing services.
2. All emergency services in either epidemic or community disaster.
3. Health education and community organization programs for the purpose of gaining local support for and development of local health departments meeting minimum standards.

"Within the limits of available funds, the Ohio Department of Health is intent upon providing desired assistance in the furtherance of local health programs," Dr. Porterfield declared.

QUALIFIED DEPARTMENTS

Dr. Porterfield issued a list of local departments that meet the minimum standards, (as of July 1, 1950):

City Alone—Akron, Canton, Cincinnati, Cleveland, Cleveland Heights, Columbus, Dayton, East Cleveland, Findlay, Hamilton, Lancaster, Lorain, Martins Ferry, Massillon, Middletown, Springfield, Steubenville and Toledo.

County Alone—Ashtabula, Butler, Clermont, Columbiana, Fairfield, Fulton, Geauga, Hancock, Jefferson, Lorain, Lucas, Mahoning, Marion, Meigs, Morrow, Muskingum, Portage, Preble, Seneca, Stark, Trumbull and Washington.

Combined Departments—Adams County, Brown County;

Ashland County—Ashland City;

Athens County — Hocking County — Vinton County—Athens City—Logan City—Nelsonville City;

Clinton County—Wilmington City;

Crawford County—Wyandot County;

Cuyahoga County—Bedford City—Berea City—Euclid City—Garfield Heights—Maple Heights—Parma City—Rocky River City—South Euclid City—University Heights;

Drake County—Greenville City;

Defiance County—Defiance City;

Delaware County — Madison County — Union County—Delaware City;

Erie County—Sandusky City;

Fayette County—Greene County—Washington Court House City—Xenia City;

Guernsey County—Cambridge City;

Hamilton County—Cheviot City—North College Hill City;

Huron County—Norwalk City;

Lawrence County—Ironton City;

Logan County—Shelby County—Bellefontaine City—Sidney City;

Medina County—Wadsworth City;

Miami County—Troy City;

Montgomery County—Miamisburg City;

Richland County—Mansfield City;

Sandusky County — Wood County — Bowling Green City;

Summit County—Cuyahoga Falls City;

Tuscarawas County—Dover City;

Wayne County—Wooster City.

Ohio Civil Defense Program . . .

Organization Meetings Are Held Throughout State; Medical-Health Division of Governor's Board Coordinating Action With Other Units

THE Ohio civil defense program is quickly taking shape, with a number of sessions already out of the way and others planned for the next few weeks.

The Ohio civil defense program is administered by the Ohio Civil Defense Board named two months ago by Governor Frank J. Lausche shortly after the onset of the Korean situation.

Dr. John D. Porterfield, State Director of Public Health, was named to the Governor's advisory board to head the multi-faceted medical and health division. Dr. Porterfield, in turn, named a 15-man board to advise him in the various and diversified phases of the health problem.

The pattern followed in setting up the Ohio program was one based on a plan laid down by the Federal government. Regional and municipal plans follow the state and Federal plan. This aids in the coordinating of assistance between towns, areas, and the state in the event of emergency.

Under the direction of Dr. A. B. Garrett of Ohio State University, several meetings covering radiological warfare and treatment have been held at the University. Dr. Garrett attended a special school at Oak Ridge preparatory to conducting the discussions and class sessions.

The first series of comprehensive meetings on the over-all plan for civil defense was scheduled for the last few days of October and the first week of November in each of the five civil defense areas of the state. Meetings were scheduled for Columbus, Canton, Toledo, Cleveland and Cincinnati starting on October 30 and running through November 8.

At these meetings mayors, county commissioners, fire chiefs and, if there had been one appointed, the civil defense director for each municipality in the area would be briefed by various civil defense officials. General Leo Kreber was to talk on the nature of the over-all program; Col. William E. Warner, State Director of Civil Defense, would report on activities to date within the state; General Kenneth Cooper, General Kreber's assistant, was to talk about ways and means of developing civil defense units in municipal areas; Colonel George Mingle of the State Highway Patrol was to speak on plan protection and police measures. Charles R. Scott was to speak on fire prevention and services and Ralph E. Dwork, who is chief of the professional training branch of civil defense for Ohio, was to speak for Dr. John Porterfield on health services.

It was pointed out by Dr. Porterfield that the main purpose of these meetings was to instill in the minds of those city and county officials attending them the importance of establishing civil defense units.

To be published by December 1, is a booklet outlining procedure for organizing for civil defense at the local level.

This manual will carry detailed information on proposed medical-health activities of a local civil defense program as a guide for local committees. Dr. Porterfield suggests that local medical-health committees proceed somewhat slowly in setting up their programs, pending receipt of this manual. He points out that it would be advisable to have the activities in all counties as uniform as possible.

During the last week in September, more than 70 health commissioners, meeting in Columbus for their 31st annual conference attended a special pre-convention session covering civil defense and their important part in its operation.

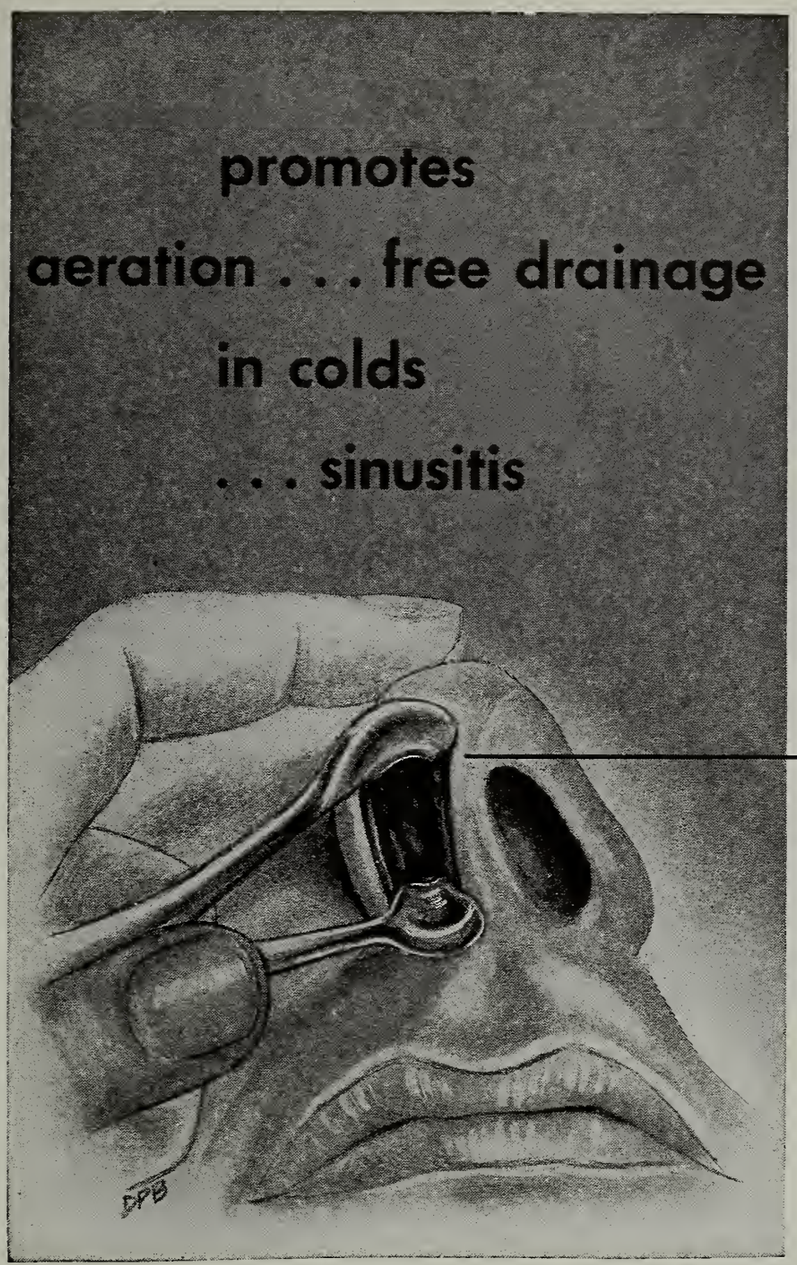
They were addressed by Governor Lausche as well as members of Dr. Porterfield's advisory board. At the close of sessions official Army sound films on the atomic bombing of Japan were shown. These films, incidently, were scheduled for use at the five regional meetings mentioned.

Clinics on Epilepsy To Continue in 1951

A series of 40 special clinics on epilepsy will be conducted in Ohio during 1950-1951 under the auspices of the Ohio Society for Crippled Children. The Society's project on epilepsy was initiated in 1946 to circulate information about the disorder and to increase public understanding of it.

Family physicians are invited to refer patients with epilepsy symptoms to the clinics for diagnosis and recommendations. The Society announced that because of increased demand for the medical services of special clinics, three additional physicians have been appointed as consultants. They are Dr. Max T. Schnitker, Toledo; Dr. John D. O'Brien, Canton; and Dr. Nathaniel R. Hollister, Dayton. Dr. Milton M. Parker, Columbus, continues as general consultant.

Headquarters for the Ohio Society for Crippled Children are at 5 W. Broad St., Columbus.





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Wyandot Memorial Hospital Is Dedicated at Upper Sandusky



This is the architect's sketch (McLaughlin and Keil of Lima) of the Wyandot Memorial Hospital, recently dedicated and now open for community use.

Another milestone in the hospital building program in Ohio under the Hill-Burton Act was marked when the Wyandot Memorial Hospital at Upper Sandusky was formally dedicated on September 10—and opened to receive patients a short time later.

The Wyandot Memorial was one of the smaller hospital projects in much-needed hospital areas which started from scratch under the Hill-Burton plan.

A one-floor plan which accommodates 31 beds and 10 bassinets, the hospital was built at a cost of $411,000, approximately $137,000 of which was furnished by Federal grant-in-aid funds.

Fred J. Milligan, Columbus attorney and native of Upper Sandusky, was principal speaker for the gala occasion which brought an estimated 3,000 persons out. Taking an active part in the celebration were the Wyandot County Band and the American Legion Drum and Bugle Corps. The dedication ceremonies were broadcast over Radio Station WMRN, Marion.

Active in the program was Dr. J. Craig Bowman, of Upper Sandusky, recently Councilor of the Third District of the Ohio State Medical Association, who was one of the guiding factors in realization of the hospital from the early planning stages. Dr. Bowman has been appointed a member of the Board of Governors of the hospital.

Also active in the program were Anthony J. Borowski, Dr. P. H., chief of the Office of Hospital Facilities of the Ohio Department of Health, Columbus, and Mr. George Fishback, also of the Hospital Facilities Office.

Named chief of the new hospital staff is Dr. Bernard A. Maloney, of Upper Sandusky.

Preliminary results of the census indicate a population in the Nation of 151,000,000, an increase of 19,000,000 over that of 1940.

Tax Roundup Article To Appear In December Issue

Important changes have been made in the Federal Income Tax structure. These changes will be incorporated in a general explanation of Federal and State taxes, especially as they pertain to physicians, which will appear in the December issue of *The Journal.* Look for this summary of all-important tax obligations.

A. A. A. S. To Meet in Cleveland

The American Association for the Advancement of Science will hold its meeting in Cleveland, December 26-30. Programs of particular interest to physicians and researchers in the medical sciences include those of the following sections and affiliated organizations:

Section on Physics; Section on Chemistry; Section on Zoology; Subsection on Medicine; Subsection on Denistry; Subsection on Pharmacy; Oak Ridge Institute of Nuclear Studies; American Society of Parasitologists; American Society of Zoologists; American Microscopical Society; Biometric Society, Eastern North American Region; American Dietetic Association; Alpha Epsilon Delta, Premedical Honor Society; Society of the Sigma Xi; United Chapters, Phi Beta Kappa.

The 150-Booth annual science exposition will be featured in the Cleveland Public Auditorium.

State Welfare Director John H. Lamneck recently announced that the Ohio Department of Public Welfare had purchased the General Protestant Orphans' Home property at Cincinnati and will proceed to convert it into a receiving hospital as soon as possible.



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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

BASIC CIVIL DEFENSE PLANS NOW BEING PREPARED

This is a word of advice to the Emergency Medical Service Committees (Civil Defense Committees) of all County Medical Societies:

Don't get the jitters; don't get over-anxious to get going.

Sounds like strange advice, doesn't it? Usually the plea is to get going immediately.

We're not trying to discourage interest nor are we criticizing work already done by some of the local committees. The point is simply this:

Planning for the medical phases of civil defense should be more or less uniform. Recommendations for such planning are now being compiled at national and state levels. This material should be available within the next few weeks. It will be sent to local medical emergency committees as soon as available, to be used as a basis for local planning and local set-ups.

Obviously, conditions in areas differ. A plan used in one spot may have to be revised to fit conditions in another. Nevertheless, much of the basic planning should be uniform. Plans put together too quickly or before uniform policies and procedures are worked out and presented for local guidance may have to be scrapped.

The idea behind this advice is not to minimize the importance of civil defense planning and action, but merely to throw out a caution sign against premature or too hasty action.

MR. RAYBURN COMMENTS ON LOBBIES

You've heard a lot lately about the labor lobby, farm lobby, business lobby, medical lobby, and what-have-you. Those who want the public to think you're a scoundrel, try to identify you with some so-called "lobby." What about these lobbies?

A recent issue of the *United States News* published an interview with Sam Rayburn, speaker of the House of Representatives and who was elected to Congress 38 years ago. Mr. Rayburn knows Congress, knows politics, knows people and knows lobbies. Here are some interesting quotations from the interview:

Q *How much influence do lobbyists have?*

A Well, now, it depends upon what you mean by lobbyists. People are called lobbyists, and, of course, the word "lobbyist" has a bad sound. Some so-called lobbyists are men of outstanding ability, honest men who would tell you the truth and are helpful to committees. Now that kind of lobbyist is very helpful because he has studied one question for many years and maybe some of the members of the committee hadn't studied it at all. Members generally want to learn about it in order to have both sides honestly put forward so they can make a sane, sensible judgment. Also there are lobbyists of the sort usually talked about, but they don't come to see me.

Q *You feel that different groups should get the chance to put their views to Congress?*

A Of course. And that will always be true. Some people who hire people to come here to Washington to represent them make mistakes in the type and character of man they get. But, as far as any of this so-called lobbyist influence in any pernicious way influencing members of Congress, that just doesn't exist, in my opinion.

Q *What about the social lobby? Do they pull much weight in Congress?*

A No. I'll tell you a story about that. There was a very popular man who represented rivers and harbors groups. He knew a lot about the subject. When he went before a committee he was helpful. He built up wonderful friendships among the membership. When he would invite people out to dinner, they wanted to go because they didn't feel he was going to talk business.

Another fellow, probably with as much ability but not the personality, came here. He wanted to know how he could get to be the same kind of man the other fellow was, because he would like to give dinners and make friends, etc. But I said, "You make your friends first and then, if they want to dine with you, that will be fine, but you are not going to buy any friendship or influence around here with a dinner."

Q *Is a member of Congress influenced much by the mail he gets?*

A I would think so, but I'll tell you a remarkable thing about congressional mail. You'll find, if you'll look over your correspondence for about six months, that in all probability from 5 to 10 per cent of the people have written 90 per cent of the letters. The fellow that's back there and satisfied and things are going all right so far as he's concerned, you don't hear from him. It's the fellow that's discontented or unhappy about something.

Q *Do you think that the members of Congress are influenced a good deal by the leading constituents in their districts who may write to them from time to time?*

A Yes. And the correspondence of members of Congress has increased manyfold since I became a member of Congress.

Q *Do you think members are impressed by letters that are obviously individual and not a part of propaganda?*

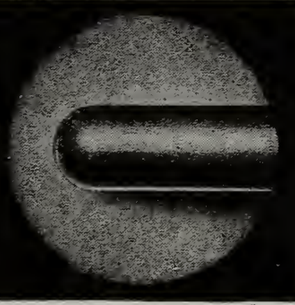
A That's correct. To an individual who is a friend they certainly pay a lot of heed.

Q *Or some individual whose opinion in the community counts for something?*

A That's right.

Q *We've heard from time to time that some*

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1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

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members of Congress maintain lists of what they call leaders in their community—is that so?

A Practically all of them do.

Q *In other words, these are people whose opinions they respect or whose opinions they regard as influential?*

A And that they seek advice from some of the time.

Now what did Mr. Rayburn say? Well, a so-called lobby is not necessarily bad—many of them serve a useful purpose and are sincere in their motives. Congressmen like to hear from the folks back home and respect the letters they get from their constituents, especially letters written by responsible citizens.

The November 7 election is now history. Ohio voters elected Congressmen to serve for the next two years. How about getting in touch with YOUR CONGRESSMAN? Congratulate him and offer your coöperation. You'll want to write to him many times in the future. Now would be a good time for an icebreaker

---

OREGON DOCTORS WIN FIRST ROUND OF BOUT WITH U. S.

The Oregon medical profession won the first round in its bout with the Federal Government which has charged it with violating the Sherman Anti-Trust Act.

On September 28, Federal Court Judge Claude McColloch ruled that Oregon's "organized medicine" had not violated the Sherman Anti-Trust Act in its prepaid medical service plan.

The government charged that the Oregon State Medical Society, a number of county societies and several physicians, sought to monopolize the field of prepaid medical care by refusing to deal with private agencies and by disciplining physicians who did deal with them.

Judge McColloch wrote: "I hold that the Oregon Physicians Service is not a conspiracy, but rather an entirely legal and legitimate effort by the profession to meet the demands of the times for broadened medical and hospital service, eliminating the evils of privately owned concerns as well as the element of private profit."

The government has announced its intention of appealing the McColloch decision.

WHAT DO YOU MEAN "FREE CHOICE"?

Those who contend that any system of compulsory health insurance—England's or the one proposed by Mr. Truman and Mr. Ewing—provides "free choice" of physician have another guess coming. There just isn't free choice as revealed by the following article published on Page 1 of the September 17 issue of *The London (Eng.) Times:*

"The Ministry of Health announces that after October 1 it will no longer be possible for a patient under the National Health Service automatically to change to another doctor except on removal to a different address.

"If a patient wishes to change while remaining at the same address, he must either obtain the consent of his present doctor or send his medical card to the executive council with a letter telling them of his intention. If he applies to his executive council, the patient will be entitled to choose a new doctor normally 14 days after the council have received his letter and medical card."

WHAT DO YOU PROFESS?

John Schoff Millis, Ph. D., LL. D., president of Western Reserve University, speaking before the Medical Alumni Association of that University, directed some thought-provoking consideration on the question of what is a profession.

After he had called attention to several definitions of the word, Dr. Millis concluded: "It seems to me that the true meaning of the word 'profession' can be obtained only from the verb from which the word is formed, namely '*profess.*' I shall therefore change my question to 'What do you profess?' That is, what do you believe? What is your faith? What do you hold to be the supreme truth?"

Continuing his discussion, Dr. Millis had this to say: "We in America accept as demonstrated that man, unlike any other occupant in the known universe, has mind, spirit and free will. The possession of these three attributes, at least in potential form, so distinguishes man that he is entitled to special privileges—those we describe as Life, Liberty and the Pursuit of Happiness. Because he can understand by intellectual mastery, because he can appreciate by spiritual insight, and because he can act rationally through the operation of his will, man is the unique part of the universe and must be provided with unique rights and responsibilities. This is, in my opinion, what you profess. This is your fundamental belief, this is your guiding faith which makes the practice of medicine a true profession.

"If you will accept my definition of your profession, then certain conclusions about your practice follow. If your profession is that the individual man counts, and never men in the mass, then the practice of medicine must be built around the individual patient and not around a collective society. The profession of medicine must be individualized, not collectivized. If we believe as I think we do we will reject all mass plans, all so-called socialized plans. . . . Though we must reject any plan which concerns men in the mass, we must be interested in and sympathetic to the needs of *every* man."

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Hospital Approval Program . . .

American Hospital Association Proposes Taking Over a Traditional Function of the American College of Surgeons; A. M. A. Takes Issue

CHANGE in the method which has been in operation for many years pertaining to standardization of hospitals and the approval of hospital activities will be made in the near future if action taken by the American Hospital Association at its recent convention in Atlantic City is carried out.

The nationwide hospital approval program has been conducted by the American College of Surgeons for the past 25 years. This would be discontinued by the College of Surgeons under the action taken by the hospital association and the activity would be taken over by the hospital association.

Following is an editorial published in the September 30 issue of *The Journal of the A. M. A.* reviewing the action of the House of Delegates of the American Hospital Association and presenting some pertinent comments on that action:

* * *

The proposal is said to call for the establishment of a commission which would include 13 hospital trustees, six hospital administrators and six physicians and surgeons, three to be appointed by the American College of Surgeons and three by the American College of Physicians.

This change of procedure in standardizing hospitals has been under consideration by the American College of Surgeons and the American Hospital Association for several months. The American Medical Association was not invited to participate in the early discussions, although the Association for many years has been in inspection and approval programs. In fact, it was quite by accident that an official of the American Medical Association learned what was contemplated. Immediately he requested further consideration, but little progress was made in developing a satisfactory joint program. There seemed to be little doubt that at least some voices in the American Hospital Association wanted their Association to be "plaintiff, judge and jury" in any standardization program.

In the September issue of *Hospitals* appears a report by John N. Hatfield, then president of the American Hospital Association. This report was published *before* the hospital group met in Atlantic City. After claiming credit for the American Hospital Association for various accomplishments, Mr. Hatfield presented a plea for taking over the hospital standardization program of the American College of Surgeons. He revealed that November had been discussed as the date for transfer. The Board of Trustees of the American Hospital Association on Aug. 5, 1950, adopted the following resolution:

> WHEREAS, The American College of Surgeons, through its hospital standardization program, has made a most significant contribution to improving the quality of hospital care for the American people; and
>
> WHEREAS, It is the understanding of the American Hospital Association that the American College of Surgeons is withdrawing from the hospital standardization field; and
>
> WHEREAS, The American Hospital Association believes that a hospital standardization program is vital to the continued improvement of hospital care; and
>
> WHEREAS, The membership of the American Hospital Association for many years has expressed interest in having the American Hospital Association conduct a hospital standardization program; and
>
> WHEREAS, It is traditional in American life that organized groups shall assume responsibility for improving quality through standardization of the programs conducted by the members of such groups; and
>
> WHEREAS, The members of hospital governing boards and the organization which represents them are the logical group for furthering the improvement of hospital care through national standardization, now therefore be it
>
> *Resolved,* That the American Hospital Association establish a hospital standardization program; and be it further
>
> *Resolved,* That the American Hospital Association invite interested organizations of the medical profession to cooperate in the development of standards relating to the practice of medicine in hospitals; and be it further
>
> *Resolved,* That other professional organizations concerned with the problems of hospital standards be invited to cooperate with the American Hospital Association in a hospital standardization program.

When the Board of Trustees of the American Medical Association learned of the pending action of the Hospital Association, it sent a telegram to the hospital convention requesting delay of action "until the principles involved could be thoroughly discussed by those most concerned, namely, the American Medical Association, the American Hospital Association and the American College of Surgeons." Until then no representative of the American Medical Association had been invited to discuss the standardization program at the Atlantic City convention. After dispatch of the telegram, Dr. Elmer Henderson, President of the American Medical Association, and two members of the Board of Trustees went to Atlantic City to discuss the problem with officials of the Hospital Association. In spite of this, however, the delegates of the American Hospital Association adopted a resolution authorizing their board of trustees to establish a standardization program.

For some years groups of medical specialists have denounced a practice in some hospitals which results in these physicians' being em-

ployed by the hospitals, which in turn submit bills to the patients for the services rendered by the specialists. Radiologists, anesthesiologists and pathologists have been particularly concerned by the trend. The House of Delegates of the American Medical Association has given careful consideration to this growing trend and at the 1950 annual meeting adopted a resolution protesting the practice and urging physicians and medical societies to recognize their responsibilities and medical ethics.

Now the hospitals apparently want to extend further their control over medical practices and superimpose lay judgment on professional knowledge and ability. By their decision to authorize the American Hospital Association to undertake an inspection program for hospitals, the delegates to the convention of the Hospital Association indicated an obvious willingness to encourage further inroads on professional freedom.

We hope that the Board of Trustees of the American Hospital Association will interpret broadly the directive from the delegates to establish a standardization program "after consultation with other organizations." The medical profession will not allow professional staffs of hospitals to fall under the complete control and domination of hospital trustees and administrators. In any hospital each participating group has certain responsibilities to the hospital, the patients, the community and to each other. Physicians have as one of their responsibilities the welfare of their patients, and they cannot and will not compromise in this respect. Physicians know better than lay groups the medical needs of patients. They are spending their lives determining these needs and their solution. If the American Hospital Association proceeds to usurp the rights of professional groups to determine the best medical standards, it can expect, to say the least, some very interesting developments. One thing is certain: The American Medical Association will not step quietly aside if the medical profession is convinced the welfare of its patients is jeopardized. It has under discussion its own hospital standardization program in preparation for such an eventuality.

"The United States is, at present, the place of choice for the study of venereal disease problems and control methods, and this should be borne in mind in directing the training of personnel for combating venereal disease throughout the world," a World Health Organization report states.

The University of Michigan School of Public Health, Ann Arbor, is offering its third inservice training course in waterworks problems on February 15 and 16, 1951.

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Buckeye News Notes . .

Canal Winchester—Dr. Roger M. Gove, superintendent of Columbus State School, discussed the value of mental health at a meeting of organizations sponsored by the Mental Health Committee of the Madison Grange.

Cincinnati—Dr. David H. Blankenhorn has been assigned to a station in Vienna with the U. S. Army Medical Corps. Dr. Blankenhorn announced that Mrs. Blankenhorn was scheduled to accompany him to Europe.

Cincinnati—The Southwestern Ohio Society of General Physicians held an all-day seminar at the Hotel Gibson on October 1. The subject of the seminar was arthritis and the guest speaker Dr. Edward F. Rosenberg, of Chicago.

Cincinnati—Dr. K. W. Ascher, assistant professor of ophthalmology, University of Cincinnati College of Medicine, gave two courses at the Annual Meeting of the Academy of Ophthalmology, held in Chicago, October 9-13.

Cincinnati—Marion A. Blankenhorn conducted a three-day medical institute at the Holston Valley Community Hospital, Kingsport, Tenn.

Cincinnati—Dr. David W. Heusinkveld, Councilor of the First District of the Ohio State Medical Association, addressed the Cincinnati Dental Society on the subject of "Socialized Medicine." Dr. L. Howard Schriver, a Past-President of the Association, also spoke briefly, denouncing compulsory health insurance proposals.

Cleveland—Dr. F. Mason Sones, formerly of the Department of Pediatric Cardiology, Henry Ford Hospital, Detroit, has joined the medical staff of the Cleveland Clinic. Dr. Sones will have charge of the cardiac catheterization laboratory.

Lorain—Dr. Oscar B. Markey, Cleveland, was guest speaker at the annual meeting of the Lorain County Mental Hygiene Association.

Martins Ferry—Dr. R. H. Wilson was honored at a banquet sponsored by the Junior Order of United American Mechanics. Among honors awarded Dr. Wilson was a certificate of membership in the International Fellowship of Surgeons.

Sparta—Dr. Robert A. Vogel, for the past year health commissioner for the combined district comprising Delaware-Union-Madison counties, now has Morrow County added to his responsibilities. Dr. Frank M. Hartsook of Cardington, recently resigned as Morrow County health commissioner.

Toledo—Dr. Howard Holmes was honored by the Toledo Public Health Association with the presentation of a plaque for his direction of the tuberculosis clinic and registry at the Toledo Health Department for the past 10 years.

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Do You Know? . . .

Dr. Claude S. Perry, Columbus, and Dr. Charles E. Holzer, Sr., Gallipolis, served on the 31-member Ohio Governor's Committee for National Employ the Physically Handicapped Week. The committee furnished the leadership for the fifth annual state-wide campaign conducted early in October.

* * *

Among those who took part in the annual meeting of the Ohio Society for Crippled Children in Columbus, October 14-15, were: Dr. Max T. Schnitker, Toledo, consultant for the epilepsy project; Dr. Lillian Marks, medical director of services for crippled children of the State Department of Public Welfare, Columbus; and Dr. Ralph W. Holmes, Chillicothe, a director of the Society.

* * *

Dr. Thomas H. Sutherland, Marion, secretary of the Aero Medical Association, has been instrumental in arranging a conference of representatives of Latin American nations interested in study and research in aviation medicine to be held in Mexico City next year.

* * *

The National Heart Institute in its two years of operation has awarded 167 heart research fellowships to outstanding students in the medical and allied fields, Dr. Leonard A. Scheele, Surgeon General of the Public Health Service, announced. Grants to September 30 totaled $521,702.

* * *

Secretary of Defense George C. Marshall on October 4 named Ohio's Dr. Richard L. Meiling, director of medical services for the Department of Defense, as chairman of the Department's Blood Donor Campaign. Dr. Meiling will act as liaison with the American National Red Cross, and will direct and coordinate the program with the Department of Defense.

* * *

Dr. Gordon E. Savage, formerly health commissioner for Greene and Fayette Counties and the City of Xenia, has been named health officer for the Southwest District of the Ohio Department of Health with headquarters in Dayton, Dr. John D. Porterfield, state health director, announced. Dr. Savage is the first of five district health commissioners to be appointed for the newly created Health Districts.

* * *

Dr. Frederick T. Merchant, president-elect of the Marion County Academy of Medicine, has been called to active duty, as Assistant Chief, Surgical Consultant's Division, Office of the Surgeon General of the Army, Washington, D. C.

Veterans Administration

Nearly three-fourths of all disabled veterans on Veterans Administration disability compensation rolls are drawing their monthly checks because of general medical and surgical disabilities.

This fact was disclosed in a V. A. analysis of the nearly 2,000,000 disabled veterans on rolls as of June, 1950.

In addition to the 73 per cent with general medical disabilities, the analysis revealed another 23 per cent of the veterans with neuropsychiatric conditions and the remaining four per cent with tuberculosis.

Forty-two per cent of the veterans in the general medical and surgical category, the study showed, had disabilities involving joints, muscles and tendons.

The analysis compared the degree of disability of veterans of World War II, World War I and the regular establishment—all of whom are entitled to compensation for service-connected disabilities.

About six out of every ten World War II veterans on the rolls had disabilities rated at 20 per cent or less; five out of ten World War I veterans were in the 20-per cent-or-under class, and only four out of ten members of the regular establishment were in that category.

* * *

Veterans of the Spanish-American War, Boxer Rebellion and Phillipine Insurrection are now eligible for out-patient medical care without regard to service-connection, the Veterans Administration announced.

Regulations implementing their right to such care, based on Public Law 791, 81st Congress. To be eligible, a veteran must have served some time between April 21, 1898, and July 4, 1902, (or July 15, 1903, if the service was in Moro Province, Philippine Islands), and was discharged other than dishonorably.

An estimated 118,000 veterans have become potentially eligible for full medical and dental care in V. A. clinics, or at home by fee basis physicians and dentists for any illness or disability.

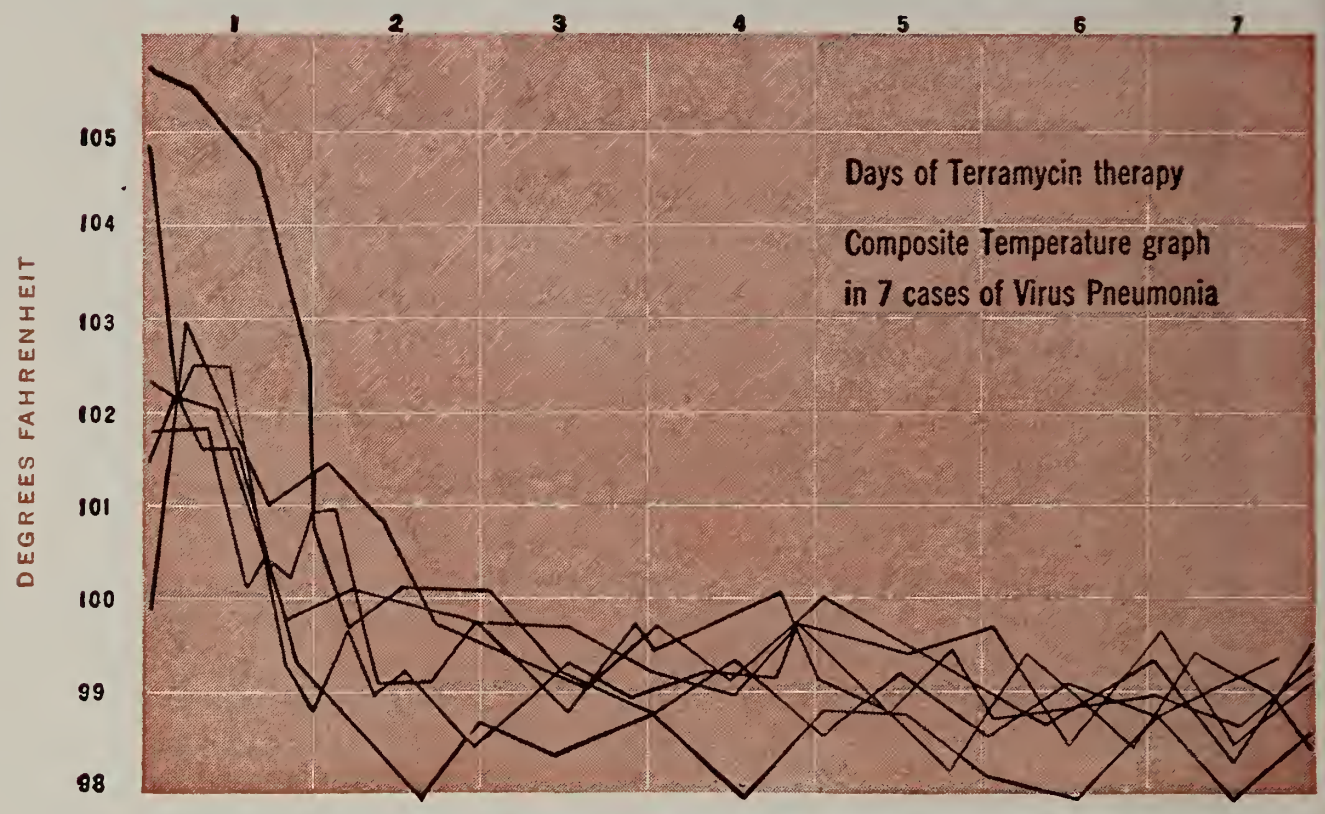
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About 9,000,000 persons were added to the population at ages 25-64 between 1940 and 1949. This age group constitutes the main source of the industrial and agricultural manpower.—Metropolitan Life.

* * *

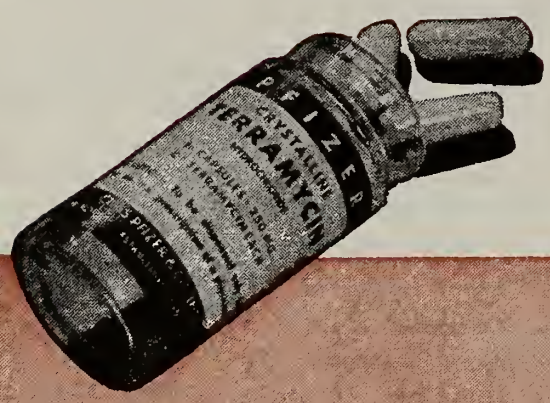
The Medical Society of the District of Columbia recently honored radio's "Dr. Christian" (Jean Hersholt) for extolling the best qualities of the physician and impressing upon the public the value of a close relationship between patient and family doctor.

PRIMARY ATYPICAL VIRUS PNEUMONIA



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"Prompt fall in temperature occurred in every patient within thirty-six hours after the first dose of terramycin, and in no case was there a febrile relapse."

"Demonstrable clinical improvement was usually evident within a few hours after institution of therapy."

Melcher, G. W.; Gibson, C. D.; Rose, H. M., and Kneeland, Y.: J. A. M. A. 143:1303 (Aug. 12) 1950

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"The response to terramycin therapy was considered excellent in every case, and there were no cases in which treatment failed."

Melcher, G. W.; Gibson, C. D.; Rose, H. M., and Kneeland, Y.: J. A. M. A. 143:1303 (Aug. 12) 1950.

Dosage: On the basis of findings obtained in over 150 leading medical research centers, 2 Gm. daily by mouth in divided doses q. 6 h. is suggested for most acute infections.

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1. *Blake, F. C.; Triou, G. J., and Wagner, R. R.; Yale J. Biol. and Med. 22:495 (July) 1950.*
2. *Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950.*

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In Memoriam . . .

Willard P. Bowser, M. D., Berea; Western Reserve University School of Medicine, 1918; aged 55; died September 23; former member of the Ohio State Medical Association and the American Medical Association through 1948. Dr. Bowser had been a practicing physician in Berea since 1919. He was on the staffs of Community Hospital, Berea, and St. John's and Deaconness Hospitals in Cleveland. In addition to his medical practice, he was active in the Kiwanis Club and had been named "Citizen of the Year" by that body. Surviving are his widow, a daughter and a son.

Arthur C. J. Brickel, M. D., Cleveland; Western Reserve University School of Medicine, 1921; aged 54; died September 10; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Brickel had been practicing in Cleveland since the completion of his medical education. He was a member of the senior staff of Charity Hospital and a clinical instructor at Western Reserve. Writings included the medical text, "Surgical Treatment of Hand and Forearm Infection." He was a member of the Catholic Church and the Catholic Physicians Guild. Surviving are his widow, four sons and a daughter.

John W. Cogswell, M. D., Strasburg; State University of Iowa College of Homeopathic Medicine, 1906; aged 67; died September 9; member of the Ohio State Medical Association and the American Medical Association. Dr. Cogswell resided in Strasburg about five years. He formerly practiced in Newcomerstown and Somerset. During World War I, he served in the Army Medical Corps as a major. Surviving are his widow and a daughter; also a brother, Dr. Charles Cogswell, of California.

Samuel H. Davidow, M. D., Youngstown; Jefferson Medical College of Philadelphia, 1920; aged 54; died October 6; member of the Ohio State Medical Association and the American Medical Association. Dr. Davidow had practiced in Youngstown for the past 30 years. He was a member of Rodef Sholem Temple, Squaw Creek Country Club, B'nai B'rith and Phi Lambda Kappa. Surviving are his widow, two daughters, his mother, two sisters and a brother, Dr. Sidney L. Davidow, also of Youngstown.

Henry E. Fledderjohnn, M. D., New Knoxville; University of Pennsylvania School of Medicine, 1886; aged 94; died October 2; former member of the Ohio State Medical Asociation and the American Medical Association through 1933. Dr. Fledderjohnn retired from active practice in 1940 after completing 52 years in the same community. However, he returned to practice during World War II. Recently he was awarded the 50-Year Pin and Certificate of the Ohio State Medical Association. He was active in the Evangelical-Reformed Church. Surviving are two daughters, a son, and two brothers, one of whom is Dr. F. F. Fledderjohnn of New Bremen.

Harry E. Hunt, M. D., Westerville; Cleveland-Pulte Medical College, 1899; aged 78; died on or about October 1; former member of the Ohio State Medical Association and the American Medical Association through 1938. Dr. Hunt had practiced for many years in Westerville, but recently had been residing at the Ohio Soldiers' and Sailors' Home in Sandusky. He was a veteran of the Spanish-American War. He retired from practice because of illness in 1939.

Edgar M. Latham, M. D., Toledo; Toledo Medical College, 1900; aged 82; died September 28; formerly a member of the Ohio State Medical Association and the American Medical Association through 1925. Dr. Latham began his practice in Holland (Ohio) in 1900 and moved to Toledo 15 years later. Surviving are his widow, a daughter and a brother.

John F. Lindsay, M. D., Youngstown; Western Reserve University School of Medicine, 1902; aged 73; died October 11; former member of the Ohio State Medical Association and the American Medical Association through 1936. Dr. Lindsay established his practice in Salineville and continued there until 1910 when he moved to Youngstown. He retired because of ill health in 1936. He was a member of the Presbyterian Church and several Masonic orders. Surviving are his widow; two sons, one of whom is Dr. John F. Lindsay, Jr., of Cleveland; and two brothers, one of whom is Dr. Samuel C. Lindsay, of Cleveland; also a sister.

Robert F. Linn, M. D., Lakewood; Stritch School of Medicine of Loyola University, Chicago, 1938; aged 40; died September 26; member of the Ohio State Medical Association and the American Medical Association; member of the American College of Surgeons; diplomate of the American Board of Obstetrics and Gynecology. Dr. Linn began practice in 1938 in Cleveland, where he was on the permanent staff of Lutheran Hospital and on the consulting staff of City Hospital. He served in the Medical Corps during World War II. He was a member of the Cleveland Society of Obstetricians and Gynecologists and was affiliated with the Masonic Lodge. Surviving are his widow and his stepmother.

John W. McCreery, M. D., Akron; Vanderbilt University School of Medicine, 1894; aged 80;

died September 27; former member of the Ohio State Medical Association and the American Medical Association through 1924. Dr. McCreery practiced in Akron from 1918 until 1926 when he retired. One brother survives.

Adonis H. Nihiser, M. D., Vaughnsville; Ohio State University College of Medicine, 1929; aged 53; died September 20; member of the Ohio State Medical Association and a Fellow of the American Medical Association; secretary of the Putnam County Medical Society in 1946, and its president in 1947 and 1948. Dr. Nihiser had practiced in Vaughnsville for about 20 years. Surviving are his widow, a brother, a half-brother and five sisters.

Elmer Samuel Oman, M. D., Columbus; Ohio Medical University, Columbus, 1898; aged 82; died September 13; former member of the Ohio State Medical Association and the American Medical Association through 1924. Dr. Oman had practiced in Columbus for 52 years although he was in semi-retirement for several years. He was a member of the Methodist Church. Two sons survive.

Jerry C. Price, M. D., Beverly Hills, Calif; Tulane University of Louisiana School of Medicine, 1928; aged 46; died September 24; Fellow of the American Medical Association; member of the Association for the Study of Internal Secretions. Dr. Price formerly was head of the Tiffin State Hospital and also consultant for the Ohio Society for Crippled Children on the epilepsy project.

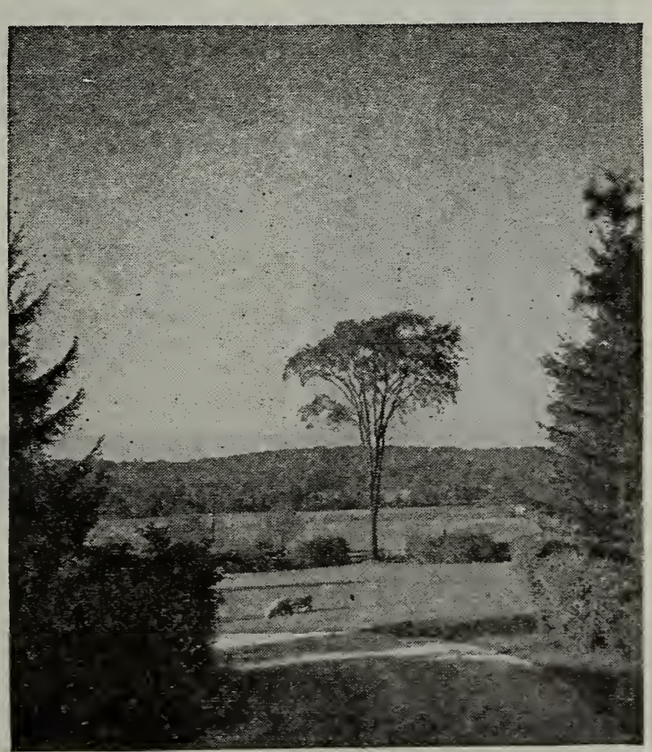
Charles H. Rether, M. D., Columbus; Hahnemann Medical College and Hospital of Philadelphia, 1899; aged 84; died September 29. Dr. Rether served virtually all of his practice in Columbus. Surviving are two sons and four daughters.

Charles Peter Sullivan, M. D., Dayton; Northwestern University Medical School, Chicago, 1912; aged 63; died September 24; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Sullivan had practiced for about 30 years in Dayton, going there after service during World War I in the Medical Corps. He was a member of the Catholic Church and the Catholic Physicians Guild. Surviving are his widow, one son and three sisters.

Walter W. Tilock, M. D., Lorain; Eclectic Medical College, Cincinnati, 1926; aged 55; died October 14; member of the Ohio State Medical Association and the American Medical Association. Dr. Titlock had practiced for about 23 years in Lorain. He was a member of the American Legion, having served during World War I. He was a trustee of the Bethany Col-

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lege, Bethany, W. Va., was a member of the Christian Temple, the Kiwanis Club and Beta Theta Phi. Surviving are his widow, a son and two sisters.

Clarence M. Valentine, M. D., Columbus; Ohio State University College of Medicine, 1908; aged 67; died October 1; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Valentine practiced continuously in Columbus beginning in 1910 with the exception of time spent in the Medical Corps during World War I. He was a past-commander of the local American Legion Post, was a member of the Methodist Church, several Masonic Orders and the Order of the Eastern Star. Surviving are his widow, a daughter, a son, a brother and a sister.

David Rowland Williams, M. D., Girard; Columbus Medical School, 1891; aged 87; died October 15; member of the Ohio State Medical Association and the American Medical Association; delegate of the Trumbull County Medical Society in 1918. Dr. Williams had practiced for approximately 58 years in Girard and recently was honored by the Trumbull County Medical Society by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association. He had served for 30 years as the Girard health officer and had served 27 years on the Girard School Board. He was an elder emeritus in the Presbyterian Church and was past-president of the Girard Kiwanis Club. Two daughters survive.

American Speech, Hearing, Association To Meet in Columbus

The American Speech and Hearing Association will meet in Columbus at the Deshler-Wallick Hotel, November 9-11. Numerous nationally recognized otologists and educators in the speech and hearing defect field will discuss current problems of interest to the profession.

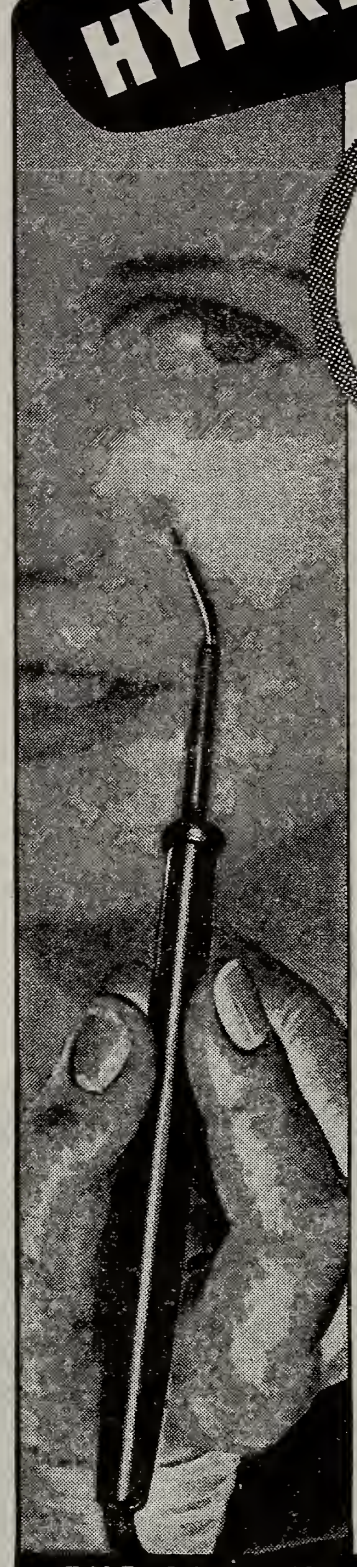
Among authorities who will be heard are Drs. Hallowell Davis, Edmund P. Fowler, Jr., Aram Glorig and Norman Canfield, as well as outstanding educators in the field of hearing and speech pathology. All physicians are invited to attend.

The Columbus Eye, Ear, Nose and Throat Society has invited outstanding representatives to address them at a dinner meeting to be held Thursday, November 9, at 6 p. m., at the University Club, 40 South Third Street. All otologists and educators are invited to attend.

Reservations at $3.50 per person must be made by November 6 to Dr. John M. Lowery, Secretary, 74 South Fifth Street, Columbus 15.

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Dr. Haden Named Medical Director of National Red Cross Blood Program

Dr. Russell Landram Haden, medical educator and recently head of the Department of Medicine at the Cleveland Clinic, has been appointed medical director of the Red Cross National Blood Program, General George C. Marshall, the organization's president announced.



R. L. HADEN, M. D.

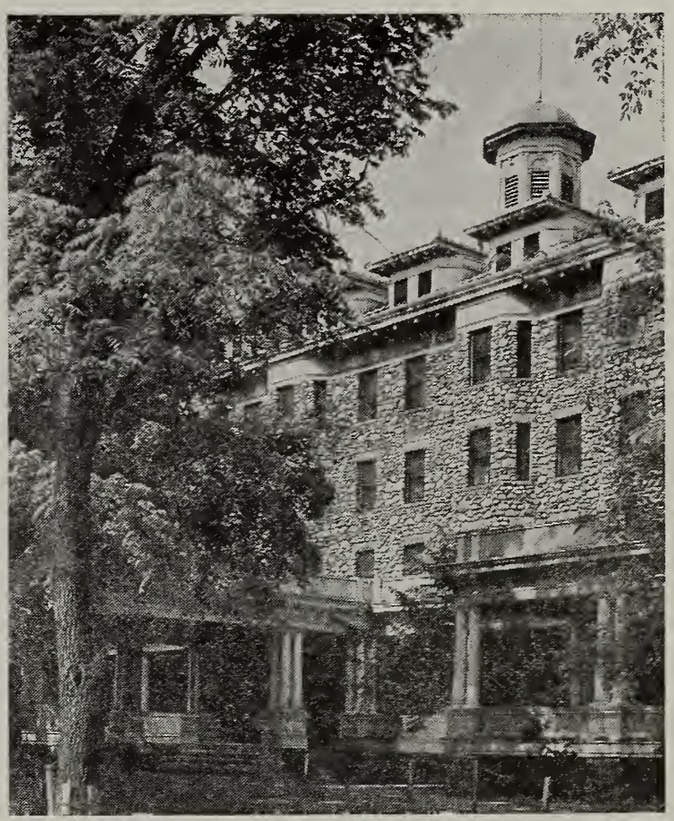
Dr. Haden will direct the medical aspects of the blood program as it is expanded to provide blood, plasma and other derivatives for the nation's hospitals and for military and civil defense needs. He will work with Dr. Ross T. McIntire, chairman of committee on medical policies and procedures. This committee of leading surgeons and hematologists is supervising the planning and development of Red Cross blood collection centers and the coordination of the country's private and institutional blood banks in carrying out the responsibilities assigned Red Cross by the military and defense authorities.

A native of Virginia, Dr. Haden graduated from Johns Hopkins Medical School. Following a residency at Johns Hopkins Hospital he became Director of Laboratories in the Henry Ford Hospital, Detroit. For a number of years he was professor of experimental medicine at the University of Kansas. He has been associated with the Cleveland Clinic since 1930.

Holder of a gold medal award from the Radiological Society of America, Dr. Haden is author of *Clinical Laboratory Methods* and *Principles of Hematology* and is a contributor to numerous medical journals. He is a Fellow of the American College of Physicians and a member of the American Society of Clinical Investigation and other professional organizations.

The Red Cross national blood progam is now operating 35 regional blood collection centers and is in process of adding seven more to the network. Civil Defense centers for the procurement of blood to meet the demands of defense preparedness are also being established in a number of metropolitan areas.

Dr. Haden succeeds Dr. Louis K. Diamond, Boston Hematologist and a member of the Harvard Medical School Faculty, who resigned to return to his duties at Harvard and at Children's Hospital where he is director of the blood bank and research laboratory.



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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

HAMILTON

The Annual Meeting of the Academy of Medicine of Cincinnati was held on Sept. 19. Guest speaker was Dr. Warren H. Cole, professor of surgery, University of Illinois College of Medicine, whose subject was, "Socialized Medicine; It's Implications and Prevention."

Addresses were given by Dr. J. Stewart Mathews, the retiring president, and Dr. Frank H. Mayfield, incoming president. Installation of new officers was a feature of the meeting.

At the Oct. 3 meeting, Dr. Barnes Woodhall, professor of neurological surgery, Duke University Medical School, spoke on "Neurosurgical Aspects of Acute Subarachnoid Hemorrhage."

On Oct. 17 in a joint meeting with the Cancer Council, Dr. J. A. del Regato, director of the Penrose Cancer Hospital, Colorado Springs, spoke on "The Present Status of the Treatment of Cancer of the Cervix."

Scheduled features of meetings for November and December are:

Nov. 14—Dr. DeWitt Stetten, Jr., Division of Nutrition and Physiology of the Public Health Research Institute of New York, "Fat and Carbohydrate Stores in Experimental Diabetes"; joint meeting with the Diabetes Council.

Nov. 28—Dr. Brian B. Blades, professor of surgery, George Washington University School of Medicine, "The Practical Application of Recent Advances in Thoracic Surgery."

Dec. 5—Dr. Arthur C. Corcoran, Cleveland Clinic Foundation, "Functional Patterns in Renal Disease: Clinical and Therapeutic Correlations."

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CLARK

The opening fall meeting of the Clark County Medical Society was held at the Ker-Deen Inn on Sept. 18 with dinner. Speaker for the occasion was Dr. Max D. Graves, Springfield, whose subject was "Psychiatric Therapy."

DARKE

Dr. Samuel E. Flook and Dr. Nathaniel R. Hollister, of Dayton, were guest speakers at the Oct. 17 meeting of the Darke County Medical Society in Greenville. The subject of discussion was "Low Back Pain from the Orthopedic and Neurological Standpoints."

GREENE

Dr. Hans G. Schulumberger, Department of Pathology, Ohio State University, was guest speaker at the Oct. 12 meeting of the Greene County Medical Society in Xenia. His subject was, "Bone Producing Lesions Found in the Scalp, Skull and Brain with Discussion on the Comparative Pathology and Embryogenesis."

MIAMI

Dr. John T. Quirk, Piqua, presented a paper on the subject, "Paroxysmal Tachycardia (Ventricular)," illustrated with lantern slides, at the Oct. 6 meeting of the Miami County Medical Society. The meeting was held at the Nurses' Home of Piqua Memorial Hospital, with dinner following. A complete report of the legislative program of the Ohio State Medical Association was presented by Dr. Hugh Wellmeier, legislative committee chairman.

Third District

(COUNCILOR: FRED P. BERLIN, M. D., LIMA)

SENECA

Dr. R. F. Machamer, Tiffin, led a discussion on the aspects of socialized medicine at a meeting of the Seneca County Medical Society in Tiffin on Sept. 19.

AUGLAIZE

At the Sept. 22 meeting of the Auglaize County Medical Society, members went on record to participate in the National Blood Program.



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The following committee was appointed to act for the Society in the program: Dr.. W. F. Schmiesing, chairman, Dr. Michael Rabe, Dr. Elizabeth Y. Kuffner, Dr. Guy E. Noble, Dr. Alfred W. Veit and Dr. Clyde W. Berry. Dr. David W. Nielson, Waynesfield, was admitted as a member at the meeting.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

PUTNAM

Dr. Charles W. Bird, Continental, was honored at the Oct. 3 meeting of the Putnam County Medical Society by being presented the Fifty-Year Pin and Certificate of the Ohio State Medical Society. The presentation was made by Dr. Fred P. Berlin, Lima, recently named Councilor of the Third District of the Ohio State Medical Association. The meeting was held at Wittenberg's Restaurant in Columbus Grove.—H. N. Trumbull, M. D., Correspondent.

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

CUYAHOGA

The program of the Cleveland Academy of Medicine for October contained the following features:

Pediatric Section, Oct. 4—"Significance of the Electro-Encephalogram in the Newborn," Dr. James G. Hughes, Memphis, Tenn.

Experimental Medicine Section of Academy and Cleveland Section of the Society for Experimental Biology and Medicine, Oct. 13—"Effect of Cortisone on Acute Streptococcal Tonsilitis," presented by a team representing the Streptococcal Disease Laboratory, Warren Air Base, Wyoming, and the Department of Preventive Medicine, Western Reserve University.

"Concentration of the Intrinsic Factor Activity of Desiccated Stomach," W. H. Prusoff, Ph. D.; Dr. G. C. Meacham, Dr. R. W. Heinle, and Dr. A. D. Welch, Departments of Pharmacology and Medicine, Western Reserve.

"Studies with Mutant Organism on the Mechanism of Sulfonamide Inhibition," J. O. Lampen, Ph. D., Department of Microbiology, Western Reserve.

"Propanediol and Its Possible Relationship to Acetone Metabolism," Harry Rudney, Department of Biochemistry.

Industrial Medicine and Orthopedic Section, Oct. 18—"Low Back Pain," a discussion by the following panel: Dr. James A. Dickson, moderator, Dr. Walter A. Engel, Dr. William A. Nosik, Dr. Rudolph S. Reich, Dr. Marvin W. Evans and Dr. Harry Sherman.

Obstetrical and Gynecological Section, Oct. 24

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—"Clinical Diagnosis of Uterine Cancer," Dr. James W. Regan.

Regular Academy Meeting, Oct. 20—"A Symposium on Uterine Bleeding," Moderator, Dr. R. L. Faulkner; panel speakers—Dr. James W. Regan, "Use of Cytologic Technic in Investigation of Uterine Bleeding"; Dr. William McK. Jeffries, "Some Hormonal Aspects of Functional Uterine Bleeding"; Dr. Allan C. Barnes, Columbus, "Abnormal Uterine Bleeding on an Organic Basis."

LAKE

Dr. John E. Williams of Cleveland addressed the Lake County Medical Society at Lake County Memorial Hospital on the subject, "Office Urology." Dr. Paul Reading, Painesville, president, presided at the meeting and Dr. Morris G. Carmody, Painesville, gave a report on the importance of all doctors voting in the November general election. There was a good attendance at this interesting session of the Society on September 12.

Dr. Herbert Clapp, spoke at the Oct. 10 meeting of the Society on "Treatment of Sterility." Dr. C. B. Elliott, speaking for the legislative committee, reported on views of state and local candidates seeking election on Nov. 7, especially in regard to medical and health matters.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

"Diseases of the Skin" was the topic of a discussion by Dr. John E. Rauschkolb, Cleveland, at the Sept. 21 meeting of the Belmont County Medical Society at the Bellaire City Hospital.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M. D., LANCASTER)

GUERNSEY

The regular meeting of the Guernsey County Medical Society was held on Sept. 21 with a noon luncheon at the Berwick Hotel, with 13 members present and Dr. Reo Swan, Cambridge, president, in the chair.

The secretary brought to the attention of members recent communications from the Ohio State and American Medical Associations, and was instructed by the president to fill out and return the blank, "Information on Component Medical Society Activities," as requested by the A. M. A.

The group voted to cancel the Oct. 5 meeting so that members could attend the Eighth District meeting in Newark.

Dr. Howard F. Van Noate spoke of the many useless details and various aggravations connected with the filing and collecting of fee bills for

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GYNECOLOGY—Intensive Course, two weeks, starting Feb. 19. Vaginal Approach to Pelvic Surgery, one week, starting March 5.

OBSTETRICS—Intensive Course, two weeks, starting March 5.

RADIATION PHYSICS—Intensive Review Course, four days, starting Nov. 29.

ROENTGENOLOGY—Diagnostic & Lecture Course First Monday of every month. Clinical Course Third Monday of every month. X-Ray Therapy every two weeks.

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Aid-to-the Aged cases. This was followed by remarks by Drs. Reo Swan, Knapp, Wells and George Swan regarding the manner in which they handle this situation. All seemed to agree that there is no simple and easy solution to this situation. Dr. George Swan also mentioned that in cases where the $200 annual emergency fund is inadequate, physicians must look to the County Commissioners for the balance due.

The scientific part of the program was in charge of Dr. Elizabeth Smith, Guernsey County health commissioner. Dr. Smith outlined the many functions of a public health department and called attention to the many ways in which she is prepared to assist physicians in public health matters. Her talk was well received by all members—Gordon Lawyer, M. D., Secy.-Treas.

WASHINGTON

Initial fall meeting of the Washington County Medical Society was held at Hotel Wakefield, Marietta, on Sept. 13. Dr. Kenneth E. Bennett, who assumed office as president when Dr. Clarence E. Ash, of Beverly, moved to Columbus in June, presided. (Dr. Ash is now in residency training at University Hospital.)

Mr. W. G. Ebert, who recently became director of Marietta Memorial Hospital, was introduced to Society members.

The president appointed a Committee on Civilian Defense consisting of the following: Drs. E. W. Hill, C. A. S. Williams and W. D. Turner.

The following new members were voted into the Society: Dr. Victor C. Whitacre, Beverly; and Dr. Larry Gale, Newport.

The educational program consisted of two films, "Streptomycin Drugs in the Treatment of Tuberculosis," and "Malnutrition in the Hospital Patient." — William R. Stewart, M. D., Secy.-Treas.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M. D., COLUMBUS)

FAYETTE

Physicians pledged 100 per cent cooperation with the Red Cross in its program at a meeting of the Fayette County Medical Society on Sept. 12 at the new Fayette County Memorial Hospital. Under plans outlined by Dr. A. D. Woodmansee, medical advisory chairman for Fayette County, physicians agreed to be on duty when the bloodmobile visited the county. They agreed to work approximately one hour each at the center. The Society also made a public appeal through the press for donors.

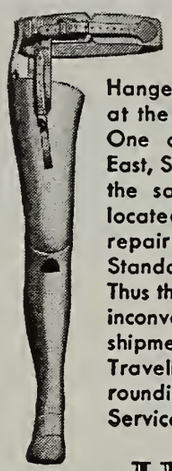
FRANKLIN

The motion picture "Medical Aspects of Atomic Energy" was shown at the Sept. 11 meeting of the Columbus Academy of Medicine. The film was produced by the Armed Forces Institute of Pathology.

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The Academy had as guest speaker at its Oct. 16 meeting, Dr. I. S. Ravdin, the John Rhea Barton professor of surgery, University of Pennsylvania, director of the Harrison Department of Medical Research, and surgeon-in-chief at the Hospital of the University. His subject was "Biliary Tract Disease."

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

The regular monthly meeting of the Lorain County Medical Society was held at the Pueblo, Lorain, on Oct. 10 with dinner. After a business session, Dr. Frank L. Meaney, Cleveland, addressed the group on the subject, "Plastic Surgery."

Woman's Auxiliary . . .

By MRS. S. L. MELTZER, Chairman, Publicity Committee
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The annual conference of county presidents and presidents-elect with state board members was held on Friday, September 22, at the Fort Hayes Hotel in Columbus. State chairmen at that time gave an outline of their programs and took part in an open discussion. The morning meeting was presided over by Mrs. George W. Cooperrider, state president. At the luncheon, honored guests included State Senator Roscoe Walcutt, Columbus, member of the Ohio Senate, Dr. H. M. Clodfelter, Columbus, Councilor of the Tenth District, and Dr. Merrill D. Prugh, Dayton, Councilor of the Second District of the Ohio State Medical Association. Senator Walcutt addressed the group following the luncheon on "The Business of the Other Fellow." The afternoon session of the program was presided over by Mrs. Farrell Gallagher, state president-elect, at which local county reports were given and an informal question and answer period was held. The fall meeting of the Board of Directors was held the preceding afternoon and evening at the Fort Hayes Hotel.

AUGLAIZE

The Woman's Auxiliary to the Auglaize County Medical Society met on Sept. 20 at the

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home of Mrs. R. H. Schaefers in Wapakoneta. Announcements of coming state and district meetings were made. The year's program was reviewed by the president. As this was the first business meeting since the state convention in Cleveland, Mrs. E. F. Heffner gave a report on the convention. The evening's program featured a review by Mrs. T. H. Will of the article, "Radioactive Iodine," as published in *Today's Health.* A new member, Mrs. David Nielson, was welcomed into the group.

CLARK

The Clark County Auxiliary launched its year's activities when it met on Sept. 18 for a business session and tea at the home of Mrs. J. H. Shanklin. Mrs. E. W. Schilke, president, presided at the business meeting at which yearbooks were distributed and committees named. Mrs. E. R. Brubaker, nurse scholarship loan chairman, reported on the third year student the Auxiliary is assisting at the Springfield City Hospital School of Nursing. She announced that a first year student at Mercy Hospital and a second year student nurse at City Hospital would be aided this year with scholarship loans. Mrs. Paul Schanher gave a report for the legislation committee and explained the doctors' draft bill which has just been passed. Mrs. H. C. Messenger, director of District 2, was a guest at the meeting and spoke briefly. The afternoon's program was a talk on "Hobbies" by Mrs. Ronald Pedrick who gave a demonstration of enamel painting of flowers on paper and textiles and told the group of many other uses of this medium. Mrs. Pedrick was introduced by Mrs. C. T. Doeing, program chairman.

Mrs. T. M. Hayes was chairman of the hospitality committee which arranged the tea following the program. Five new members were introduced by Mrs. D. J. Parsons, membership chairman: Mrs. Clyde Asbury, Mrs. Frederick Bavendam, Mrs. H. L. Guyselman, Mrs. W. E. Leeper, Mrs. R. A. McLemore.

FAIRFIELD

Doctor-husbands of the Auxiliary to the Fairfield County Medical Society were entertained at a dinner on Sept. 28 by the Auxiliary group. Early autumn garden flowers and trailing ivy decorated the dinner tables. Mrs. Chester Swett, president, gave the address of welcome. Dr. F. W. James and Dr. Leo Stenger presented some outstanding films of their European trip. Hostesses for the evening were Mrs. James, Mrs. William Jasper, and Mrs. Stenger.

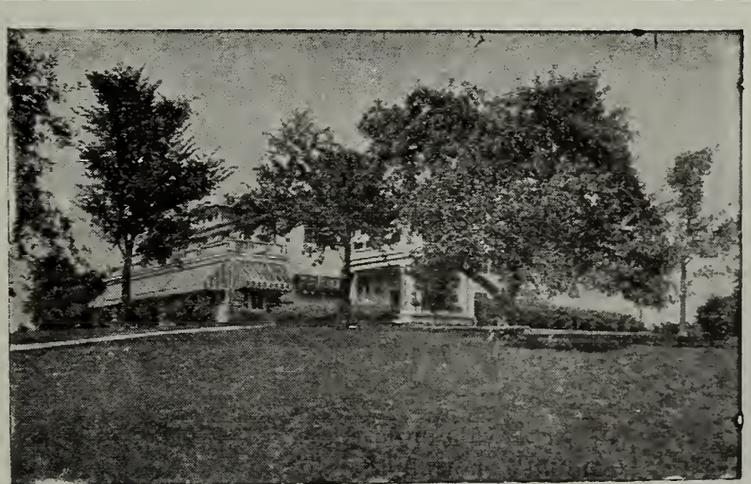
FRANKLIN

A resolution of sympathy was extended to the family of the late Cora Helen Baxter, wife of Dr. Earl H. Baxter, by the Woman's Auxiliary to the Columbus Academy of Medicine. Mrs. Baxter "was a member of numerous civic groups, and was given leadership responsibilities in all of them," the resolution states. "These were carried out by her with the greatest care and precision. Whatever she undertook, she did well. She was an extremely able executive . . ." Mrs. Baxter was a charter member of the Auxiliary and served as its president in 1946-47.

GREENE

The aims and responsibilities of organized auxiliaries to county medical societies were outlined by Mrs. George W. Cooperrider, state president, at a luncheon meeting of the Greene County Auxiliary held at Trebein Manor on Sept. 27. The speaker emphasized the benefits to be derived by the local community when such a group of organized women are working closely together.

The luncheon marked the first fall meeting of the Greene County Auxiliary and was preceded by a reception honoring Mrs. Cooperrider. Mrs. W. T. Ungard, Mrs. L. W. Sontag, and Mrs. Donald F. Kyle, served as hostesses. Mrs Cooperrider was introduced by Mrs. Paul D. Espey, president of the county auxiliary. Yearbooks were distributed at the business session. Committees were announced, and chairmen



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presented reports, the state president serving as adviser.

HURON

The Woman's Auxiliary to the Huron County Medical Society met for luncheon at the Norwalk Country Club on Sept. 8. At the business session following the luncheon, reports from committee chairmen were given and Mrs. A. H. Kimmel, state chairman for *Today's Health* and the *Bulletin*, discussed important information relating to those two publications. The Auxiliary voted that, instead of sending flowers in the event of death in the immediate family of a member, each Auxiliary member be assessed a nominal sum to be paid into the nurses' scholarship fund, and that a sympathy card be sent to the bereaved family, stating that a contribution has been made to that fund in memory of the deceased.

KNOX

Mrs. C. E. Cassaday, president, presided at the first meeting of the season of the Knox County Auxiliary held at the home of Mrs. Raymond Lord on Sept. 27. It was voted to establish a nurse's scholarship fund to be given to a girl graduate of a high school in Knox County in June, who wishes to enter nurses' training. An arrangement of fall flowers centered the table at which refreshments were served by Mrs. Lord and her assistant hostesses, Mrs. Conard and Mrs. Delbert Schmidt.

LAWRENCE

The Woman's Auxiliary to Lawrence County Medical Society held its first meeting of the year at the home of Mrs. George Hunter. Mrs. W. W. Lynd was the assisting hostess at a covered dish luncheon which was held outdoors. There was a business meeting following the luncheon, conducted by Mrs. G. N. Spears, president. Getting-acquainted games conducted by Mrs. Vallee Blagg featured the afternoon's entertainment. A new member, Mrs. Harry Nenni, was welcomed into the group.

MONTGOMERY

A luncheon meeting at Suttmiller on Sept. 12 with 89 members present featured the first fall get-together of the Woman's Auxiliary to the Montgomery County Medical Society. The project committee reported that a number of members have been assisting at the Draft Board on a volunteer service status. Members of another group are taking turns in the transportation of a crippled child to Barney Community Center for treatment. Mr. John Martin was the afternoon's guest speaker. The material for his talk, "British Socialism—America's Number One Lesson," was gathered from first

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hand study as Mr. Martin saw it in action last summer in England. The speaker, a born Englishman, had returned to his native land for an extended visit. Mr. Martin, speech director at the Oakwood High School for the past 18 years, has delivered his talk before some 45 organizations.

RICHLAND

The September meeting of the Richland County Auxiliary was held at the Woman's Club. Luncheon was served to the 33 members in attendance. Mrs. S. M. Wadsworth, Mrs. J. L. Clark and Mrs. Robert Garber were the hostesses. The business meeting following the luncheon was presided over by Mrs. H. G. Knierim, president, who gave a report on the national convention in San Francisco. The luncheon meeting in October was held at Shelby Inn. Hostesses for the afternoon were Mrs. Edward Dowds, Mrs. Elmer Jackson, Mrs. Charles Butner and Mrs. B. L. Hannam. The president, Mrs. Knierim, conducted the business meeting.

STARK

A membership tea was held on Sept. 12 by the Stark County Auxiliary at the home of Mrs. Ian B. Hamilton, chairman of the membership committee. The year's program was discussed and detailed explanations given to the 19 new members. Stark County's total membership is now 225. A board meeting preceded the membership tea. The president announced with deep regret the recent death of one of the Stark County Auxiliary members, Mrs. Harry Gauchot.

The meeting on Oct. 10 was held at the Alliance Woman's Club. The afternoon's feature was a book review by Mrs. Guy E. Byers, a member of the Columbiana Auxiliary. The Stark County Auxiliary has 9 student nurses in training.

SUMMIT

Past-presidents of the Woman's Auxiliary to the Summit County Medical Society were hostesses at a tea on Sept. 19 honoring new members into the group. Mrs. Norman E. Wentsler was chairman of the hostesses, with these past-presidents assisting her: Mrs. S. B. Conger, Mrs. J. D. Brumbaugh, Mrs. P. A. Davis, Mrs. D. M. McDonald, Mrs. C. F. Wharton, Mrs. D. M. Traul, Mrs. R. M. Lemmon, Mrs. J. Paul Sauvageot, Mrs. Frank McDonald. Mrs. Edwin W. Cauffield now heads the Summit County Group.

TRUMBULL

The Trumbull County Medical Society and its Woman's Auxiliary held a joint dinner meeting on Wednesday, Sept. 20, at the Warner Hotel. The guest speaker for the evening was Dr. Samuel Spector, associate professor at Western Reserve Medical School. The business meeting of the Auxiliary, held later, was presided over by Mrs. Allen W. Beale, president. An emergency trust fund for needy student nurses was set up with Mrs. M. T. Knappenberger, Mrs. D. R. Mathie and Mrs. John MacKay serving on the special committee.

SIXTH DISTRICT

The Trumbull County Auxiliary was hostess on Sept. 29 for the Sixth District luncheon meeting held at the Warner Hotel. Auxiliary presidents from Mahoning, Summit and Stark Counties were present as were representatives from each of the groups. The three visiting presidents were Mrs. William Evans, Mrs. Edwin Cauffield and Mrs. George Wilcoxon. Following the luncheon, Mrs. A. W. Beale, president of the local group, welcomed the guests and introduced the guest speaker, Norma Adams, who gave an interesting and informative talk on the "Western Reserve Territory and Pioneers of Medicine." Miss Olive Harmon, daughter and granddaughter of pioneer doctors in Warren was an honored guest. Mrs. Farrell Gallagher, state president-elect, talked on the purposes and aims of the Auxiliary. Mrs. Robert Lemmon of Akron, sixth district director, presided at the meeting and conducted a period of general discussion with questions and answers in which all counties participated.

ELEVENTH DISTRICT

Dr. Fred W. Dixon of Cleveland, President-Elect of the Ohio State Medical Association, designated the members of the Woman's Auxiliary as "public relations experts" of the medical profession. Dr. Dixon was the principal speaker at the Eleventh District meeting held in September at the Elyria Country Club. Dr. Dixon pointed out that good public relations are necessary to physicians for many reasons and especially at this time because of the agitation for socialized medicine. He urged that the doctors' wives become informed so that they are able to explain intelligently the reasons for the actions of the medical profession. Approximately 85 women from Huron, Erie, Richland and Lorain counties met for the luncheon district meeting. The Lorain County Auxiliary, Mrs. D. A. Russell, president, served as the hostess group.

Dr. John S. Hattery, Mansfield, Councilor of the Eleventh District of the Ohio State Medical Association, was presented as the man who introduced the resolution originating the Woman's Auxiliary in Ohio, back in 1939. He traced the background of the medical profession through its various phases to the present day. Mrs. Farrell Gallagher, state president-elect, spoke on "The Why of the Auxiliary." Mrs. George Cooperrider, state president, reported on the national convention in San Francisco and pointed

out that the goal of the National Auxiliary is that every doctor's wife be an Auxiliary member.

Mrs. C. E. Swanbeck, director of District 11, presided. She presented the presidents of the four County Auxiliaries: Mrs. E. J. Meckstroth of Erie County; Mrs. William Kauffman, Huron; Mrs. H. G. Knierim, Richland; and Mrs. Russell, Lorain. Each gave a short report of the work in her county. Special music which followed the luncheon was provided by two young pianists. The welcome address was given by Dr. S. D. Nielson, president of the Lorain County Medical Society. The program closed with a round table discussion led by Mrs. Swanbeck.

Opinions of the Attorney General

The syllabus of Opinion No. 2328, recently rendered by Attorney General Herbert S. Duffy is as follows: "Persons suffering from tuberculosis and in need of care and medical treatment, but not in need of hospital care and treatment, and not living in a tuberculosis sanitarium or hospital, are entitled to poor relief providing they have acquired legal settlement in one of the counties of the district."

* * *

The syllabus of Opinion No. 2329 is as follows:

"(1) A nurse is not authorized to exercise the office of acting health commissioner in a general health district. (2) A district board of health is authorized to appoint a public health nurse without the recommendation of a health commissioner for such district in a situation where the office of health commissioner is vacant."

* * *

The syllabus of Opinion No. 2041 is as follows:

"1. A district advisory council may fill a vacancy in the board of health of a general health district only at its annual meeting.

"2. Meetings of the district advisory council which are held subsequent to the annual meeting of said council are special meetings rather than continuations of the annual meeting."

COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Netherland Plaza, Cincinnati, April 24-26, 1951.

A. M. A. Clinical Session, Cleveland, December 5 - 8.

Radiological Society of North America, 36th Annual Meeting, Palmer House, Chicago, December 10-15.

American Academy of Dermatology and Syphilology, Annual Meeting, Chicago, December 2-7.

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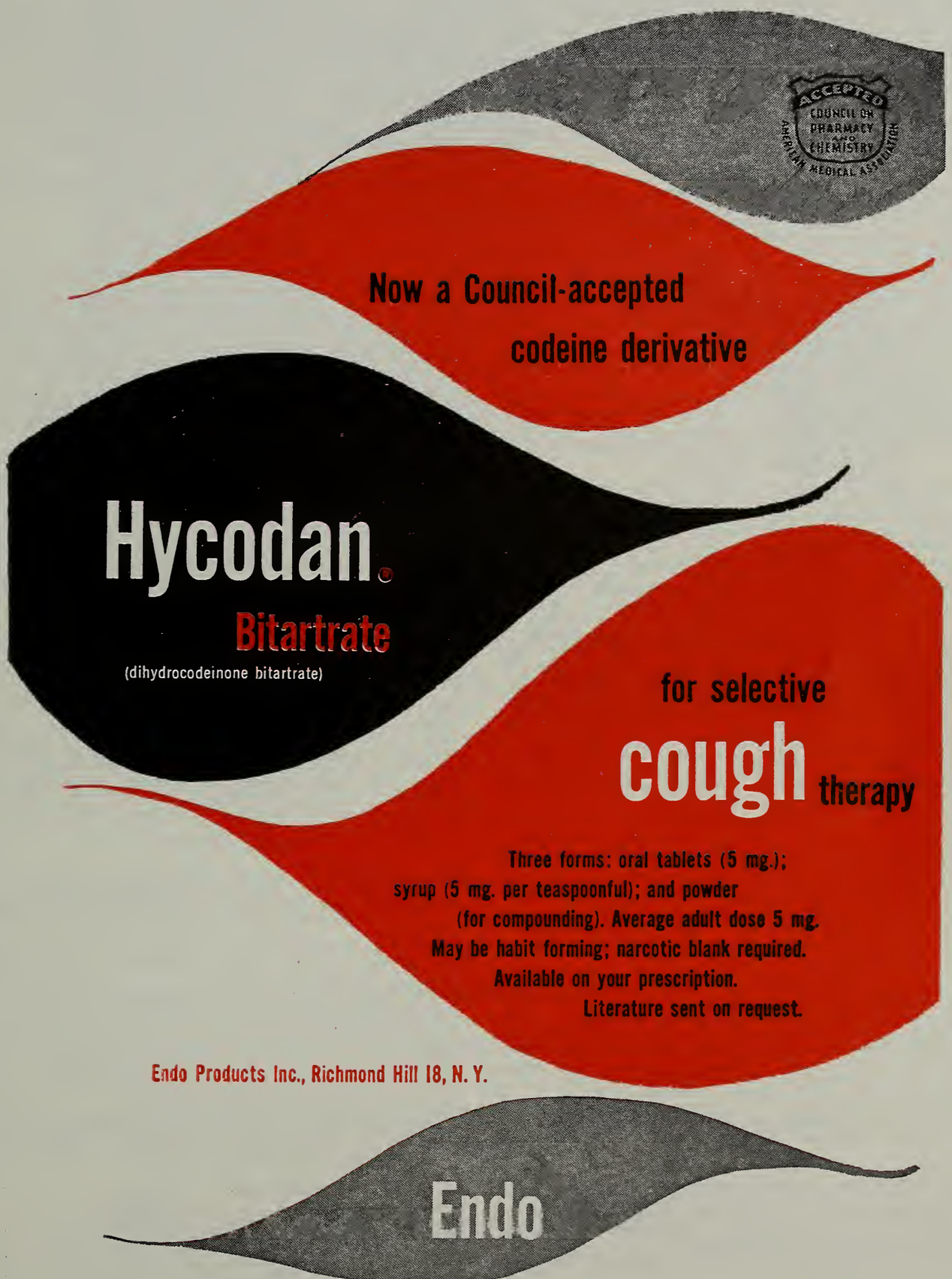
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GREENE—Ray W. Barry, President, Xenia; Robert D. Hendrickson, Secretary, Xenia. 1st Thursday, monthly.

MIAMI—W. W. Trostel, President, Piqua; G. A. Woodhouse, Secretary, Pleasant Hill. 1st Friday, monthly, except July, August.

MONTGOMERY—H. D. Cassel, President, Dayton; Paul Troup, Secretary, Dayton. 1st Friday, monthly, except July, August and September.

PREBLE—A. L. Ross, President, West Alexandria; B. R. Smith, Secretary, Lewisburg. No regular meeting date.

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THIRD DISTRICT

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HARDIN—C. L. Johnson, President, Kenton; Elizabeth Brungard, Secretary, Kenton. 3rd Thursday, monthly.

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MARION—Robert T. Gray, President, Prospect; Wm. B. Leffler, Secretary, Marion. 2nd Tuesday, monthly.

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SENECA—W. R. Funderburg, President, Tiffin; W. A. Daniel, Secretary, Tiffin. 2nd Tuesday, monthly.

VAN WERT—Roy E. Shell, President, Van Wert; T. L. Edwards, Secretary, Van Wert. 1st Tuesday, monthly.

WYANDOT—F. M. Smith, President, Sycamore; R. T. Murphy, Secretary, Carey. Last Friday.

FOURTH DISTRICT

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FULTON—Ralph W. Reynolds, President, Fayette; Paul I. Geer, Secretary, Metamora. 2nd Tuesday, monthly.

HENRY—Thomas Quinn, President, Napoleon; John Schlereth, Secretary, Napoleon. 2nd Tuesday, monthly.

LUCAS—E. A. Ockuly, President, Toledo; H. C. Gunderson, Secretary, Toledo. 3rd Tuesday, monthly.

OTTAWA—H. O. Beeman, President, Port Clinton; James I. Rhiel, Secretary, Port Clinton. 2nd Thursday, monthly.

PAULDING—K. C. Evans, President, Payne; J. M. Poitras, Secretary, Antwerp. 3rd Wednesday, monthly.

PUTNAM—M. W. Palestrant, President, Continental; C. J. Heitz, Secretary, Fort Jennings. 1st Tuesday, monthy.

SANDUSKY—H. L. Keiser, President, Fremont; E. L. Koons, Secretary, Fremont. 3rd Wednesday, monthly.

WILLIAMS—P. G. Meckstroth, President, Bryan; I. L. Colvin, Secretary, Edon. 4th Thursday, monthly.

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TRUMBULL—E. G. Caskey, President, Mineral Ridge; C. W. Mathias, Secretary, Niles. 3rd Wednesday, monthly.

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MONROE—A. R. Burkhart, Secretary, Woodsfield. 2nd Wednesday, monthly.

TUSCARAWAS—Wm. E. Hudson, President, New Philadelphia; H. F. Wherley, Secretary, New Philadelphia. 2nd Thursday, monthly.

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WASHINGTON—K. E. Bennett, President, Marietta; Wm. R. Stewart, Secretary, Marietta. 2nd Wednesday.

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SCIOTO—L. B. Hatch, President, South Webster; C. L. Pitcher, Secretary, Portsmouth. 2nd Monday, monthly.

VINTON—R. E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, McArthur. No regular meeting date.

TENTH DISTRICT

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FAYETTE—Joseph M. Herbert, President, Washington C. H.; N. M. Reiff, Secretary, Washington C. H. 1st Friday.

FRANKLIN—Grant O. Graves, President, Columbus; Oscar W. Jepsen, Secretary, Canal Winchester. 1st and 3rd Mondays, monthly.

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MORROW—L. W. Murphy, President, Cardington; F. W. Kubbs, Secretary, Mt. Gilead. 4th Tuesday, monthly

PICKAWAY—Lloyd Jonnes, President, Circleville; W. F. Heine, Secretary, Circleville. 1st Friday.

ROSS—E. H. Artman, President, Chillicothe; R. L. Counts, Secretary, Chillicothe. 1st Thursday, monthly.

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ERIE—C. J. Reichenbach, President, Sandusky; A. G. Groscost, Secretary, Sandusky. 4th Thursday, monthly.

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HURON—C. J. Cranston, President, Wakeman; G. F. Linn, Secretary, Norwalk. 2nd Wed., March, June, Sept., Dec.

LORAIN—S. D. Nielsen, President, Elyria; L. H. Trufant, Secretary, Oberlin. 2nd Tuesday, monthly.

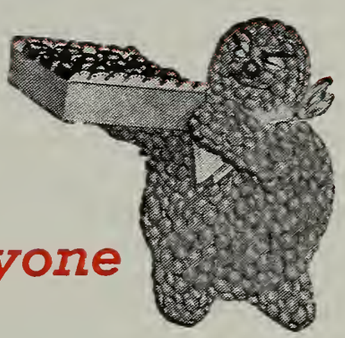
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WAYNE—John B. Beeson, President, Wooster; R. C. Paul, Secretary, Wooster. 2nd Wednesday, monthly.



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The Physician's Bookshelf

By Jonathan Forman, M.D.

Textbook of Endocrinology, edited by Robert H. Williams, M. D. ($10.00. *W. B. Saunders Company, Philadelphia, Pa.),* presents the knowledge gained in recent years about the manner in which these hormones influence bodily functions now that we have them in form. The book is made of still greater worth to you and me in that it takes up the way in which these glands play a part—often a critical role —in heart failure, hypertension, geriatrics, gerontology, immunology, hematology, and the treatment of tumors and collagen diseases. The collaborators are the men who have maintained intimate contact with the progress of both basic and clinical investigations.

The Causation and Treatment of Delayed Union in Fractures of the Long Bone, by Kenneth W. Starr. ($9.00. *Butterworth & Co. (Pubrs.) Ltd., London, England.—The C. V. Mosby Co., St. Louis, Mo.)* is the Jacksonian Prize Essay of the Royal College of Surgeons of England. The essay is divided into three parts: 1. The morphogenesis of bone; 2. The healing of fractures; 3. Delayed Union. This is a book for the library of the hospital and for the bone surgeon. Certainly the resident staff of the hospital should read as they work up their bone cases.

The 1949 Yearbook of Endocrinology, Metabolism and Nutrition, edited by Willard O. Thompson, M. D., and Tom D. Spies, M. D. ($4.75. *The Yearbook Publishers, Chicago, Ill),* is the fourth of these annual reviews which many of us have come to depend upon to gather information for us. Significant as were the developments in our knowledge of the ovary and testis, they have been overshadowed by the observations on Compound E, ACTH, and radioactive iodine. Those of us of the advance guard of those interested in soil-health relations are more than delighted with Tom Spies' review of nutrition, for he begins thus: "Because the earth's nutrients are being depleted, mankind from a nutritional standpoint is forced to live unwisely. Soil erosion, floods, and improper use of land are cutting down on man's capacity to produce food. . . . For decades the production of food and raw materials has been speeded up at the expense of soil fertility, yet maintenance of soil fertility is necessary for a long-continued system of agriculture." You will be interested in the annotation and collection of literature bearing on the problem of aging. The great problem for old people is how to replenish their cells.

Public Opinion and Propaganda, by Frederick C. Irion, ($5.00. *Thomas Y. Crowell Co., New York City),* who is the assistant professor of government in the University of New Mexico. His position as assistant director of government research has also led him to make a study of this business of shaping public opinion. The book is an attempt to present an objective description and analysis of the forces that operate within the framework of our culture to mold and change our opinion. Judging the book by the two things which I know something about in this field—communistic activities, and our own program against socialism of all sorts—I can say that the author has done a fair and objective presentation. He has, of course, covered all of the subjects now receiving such treatment by government officers of information, or by public relations officers of all the other groups that are bent on influencing people and making friends.

The Merck Manual, ($5.00. Eighth Edition. *Merck & Co., Inc., Rahway, N. J.),* contains 1,600 pages, 338 chapters on diagnosis and treatment containing 1775 prescriptions. There are new chapters on routine immunization, bedside procedures, office laboratory tests, and a list of items for the physician's bag; an outline of preoperative and postoperative care, a section on diets, and the usual conversion tables,—making this handy sized volume the best of the desk reference books. It is the work of five experienced physicians assisted by 100 nationally known physicians as consultants. No wonder that the first printing of 75,000 copies was exhausted by advance orders.

Psychiatric Sections in General Hospitals, by Paul Haun, M. D., Sc. D., ($4.00. *Architectural Record, 199 West 40th St., New York 18, N. Y.)* As Karl A. Menninger, M. D., says in his introduction, "It is too seldom reflected upon that the architects of today determine the procedures and practices of tomorrow; and in turn they must depend upon physicians who can look ahead on the basis of today's experience." Certainly he is right when he points out that our modern hospitals have been built around the operating room to the neglect of the non-surgical patient. This book attempts to meet all of the objectives for the mental case. There are eight detailed plans for the floors for a psychiatric section of a general hospital and six floor plans for incorporating a psychiatric floor in a general hospital. A working bibliography of 35 references is also incorporated. All who

have anything to do with planning a hospital will want to read this book.

Peace I Give Unto You, by Marie Winchell Walker, M. D., ($2.50. *Willing Publishing Co., P. O. Box 51, San Gabriel, California),* attempts, and quite successfully, to integrate modern psychology and practical Christianity.

Prayer Works, by Austin Pardue, Bishop of Pittsburgh, ($2.00. *Morehouse-Gorham Co., New York City),* presents in book form a series of radio broadcasts over WCAE. They were aimed at people who had personal problems.

Practical Statistics in Health and Medical Work. by Ruth Rice Puffer, ($3.75. *McGraw-Hill Book Co., Inc., New York City).* At the present time statistical work is being extended in health and medical fields. Today, progress in a science is usually dependent on the statistical approach and the analysis of the data. Hence there is great need for a text like this one.

Harvey Cushing: Surgeon, Author, Artist, by Elizabeth H. Thomson, ($4.00. *Henry Schuman, New York City),* the woman who assisted Dr. John F. Fulton write the bigger biography. In writing this shorter and more popular work Miss Thomson has used all of the new material that Dr. Fulton's work "smoked out." Here, too, we get a much clearer picture of the part that Mrs. Cushing played in Dr. Cushing's life. The Doctor's relation with his patients is more satisfactorily treated.

You and Your Heart, by Doctors H. M. Marvin, I. S. Wright, I. H. Page, T. D. Jones, and D. Rutstein, with foreword by Paul D. White, M. D., ($3.00. *Random House, New York City)* is a book written in simple terms for non-medical people, dealing with normal and diseased hearts. Its purpose is to bring some measure of enlightenment and understanding to all who read it and not with the idea of self-help. This impressive list of authors bespeaks for high quality in this book for laymen.

Pastoral Care of Nervous People, by the Rev. Henry Jerome Simpson, ($2.50. *Morehouse-Gorham Co., New York City),* written as an elementary text by a clergyman who realizes that many complaints of bodily ailing without physical basis are not self-centered whinings and lamentations, but really represent emotional abnormalities.

Textbook of Bacteriology, by Joseph M. Dougherty, Ph. D., and Anthony J. Lamberti, ($5.75. Second Edition. *C. V. Mosby Company, St. Louis, Mo.),* is a revised text for premedical and predental education as well as public health and hygiene courses.

Review of Dentistry, edited by James T. Ginn, D. D. S., ($5.75. *C. V. Mosby Company, St. Louis, Mo.),* has been prepared with a three-fold purpose in mind: to be a guide in preparing for examination, to serve as a general review for the undergraduate student, and, finally, to serve as a handbook of references. It has 790 pages set up as questions and answers.

Occupational Therapy, edited by William Rush Dunton, Jr., M. D., and Sidney Licht, M. D., ($6.00. *Charles C. Thomas, Pubrs., Springfield, Ill.),* has been written for physicians—a source book of essential information in convenient form.

Cell Growth and Cell Function—A Cytochemical study by Torbjoern O. Caspersson, M. D., ($5.00. *W. W. Norton & Co., Inc., New York City),* tells of the new methods and procedures that have been developed at the Institute for Cell Research at the Karolinska Institute in Stockholm that may be used to make a quantitative study of the chemical background of vital processes.

Clinical Orthoptic Procedure, by William Smith, O. D., ($8.00. *The C. V. Mosby Co., St. Louis, Mo.),* is a reference book on the clinical methods of orthoptics. It describes in simple language the proceedings which have proven themselves by clinical trial.

The Criminality of Women, by Otto Pollak, ($3.50. *University of Pennsylvania Press, Philadelphia, Pa.),* gives the results of brilliant investigation of the female criminal. The author shatters the age-old theory that women are less criminal than men. He concludes that women appear less criminal only because of the masked quality of their transgressions which are emphasized by their predilection for, and adeptness at, deceit.

S. Weir Mitchell—Novelist and Physician, by Ernest Earnest, ($3.50. *University of Pennsylvania Press, Philadelphia),* is the first full-length study of this pioneer in psychosomatic medicine in 21 years. Silas Weir Mitchell was considered a genius by his contemporaries—physician and for 30 years the leading psychiatrist in America. Authority on gunshot wounds, his discovery of the nature of rattlesnake venom was the foundation stone for later research in the field of immunology. No wonder he came to believe what people said of his genius.

A Symposium on Steroid Hormones, edited by Edgar S. Gordon, ($6.50. *University of Wisconsin Press, 811 State Street, Madison, Wis.),* brings us up to date in our understanding of the part played by steroid compounds in the regulation of animal function and behavior. These compounds promise to give us the next great—possibly the greatest—development in our understanding of disease processes. So each of us should prepare ourselves for the immediate future by reference to this valuable report. An index, however, would be a great convenience.



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The Ohio State Medical Journal

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JONATHAN FORMAN, M.D., *Editor*

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Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Tobacco Smoking: Some Hints of Its Biologic Hazards

CLARENCE A. MILLS, M. D.

IT may seem a long way from urban air pollution to tobacco smoking, but the connection is in fact very close. The much higher price paid by men than by women for living in dirty air[1] aroused our interest in the effects of tobacco smoking. The irritant materials of polluted air and of tobacco smoke seem to produce similar types of damage to the air passages—a chronic irritation which predisposes to such respiratory diseases as pneumonia, tuberculosis, lung cancer, and many minor complaints. It seems quite likely that much of the higher price paid by men for living in polluted air may be due to the added air passage damage brought on by their heavier tobacco smoking.

It behooves medical science to assay as clearly as possible the biological effects of this heavy tobacco usage by man. Such assay must deal separately with the effects of tobacco smoke in the air passages and with the effects of absorbed nicotine on more distant parts of the body.

SMOKING HABITS IN COLUMBUS, OHIO

The study here briefly presented is purely statistical in nature, comparing the smoking habits of different groups of disease victims or individuals with similar segments of a normal city population. Columbus, Ohio, was selected as the control survey group. Persons of both sexes and races, of all ages above 20, were interviewed in every census tract of the city. Table 1 presents a brief summary of the smoking habits found.

The classification of smoking combinations used in table 1 emphasizes pipe and cigar smoking and is used in correlation studies involving cancers and infectious diseases of the air passages and lungs where the heavy tars may play a part. In order to emphasize cigarette smoking in connection with those diseases where absorbed nicotine may be important (peptic ulcer and coronary occlusion), the smoking combination statistics of table 1 were reclassified, listing as "cigarette" any combinations which included this form of smoking.

According to these Columbus statistics, 78 to 80 per cent of white men under 50 years of age smoke, also roughly 40 per cent of white women under the age of 40 years. Colored men and women are more addicted to smoking than corresponding sexes of the white race. Cigarette smoking is most common in young adults and diminishes with advancing age, while the reverse is true with pipe and cigar smoking. This probably represents the results of advertising prop-

Submitted May 2, 1950.

The Author

● Dr. Mills, Cincinnati, Ohio, is a graduate of University of Cincinnati College of Medicine, 1922; fellow, American Medical Association; member, Ohio State Medical Association, International Leprosy Association, American Society of Tropical Medicine, American Physiological Society, American Society of Biochemists, and Central Society for Clinical Research; James T. Heady professor of experimental medicine, University of Cincinnati; and director of laboratories for experimental medicine, University of Cincinnati.

TABLE I

TOBACCO SMOKING HABITS IN COLUMBUS, OHIO

(By Age, Sex and Color)
Percentage Incidence of Smoking

Age in Years	Cigarettes Only		Pipe, Cigars or Combinations		Non-smokers	
White Men	%	No.	%	No.	%	No.
20 - 29	66.38	(233)	10.83	(38)	22.79	(80)
30 - 39	61.05	(116)	16.84	(32)	22.11	(42)
40 - 49	60.65	(131)	19.44	(42)	19.91	(43)
50 - 59	51.60	(97)	23.93	(45)	29.47	(46)
60 - 69	34.17	(41)	30.83	(37)	35.00	(42)
70 - 79	13.05	(9)	30.43	(21)	56.52	(39)
80+	5.56	(1)	47.37	(9)	47.37	(9)
Colored Men						
20 - 29	76.11	(188)	6.07	(15)	17.82	(44)
30 - 39	74.19	(138)	12.90	(24)	12.91	(24)
40 - 49	64.44	(125)	21.65	(42)	13.91	(27)
50 - 59	51.43	(90)	29.71	(52)	18.86	(33)
60 +	24.16	(36)	46.98	(70)	28.86	(43)
White Women						
20 - 29	39.68	(123)	-------	-------	60.32	(187)
30 - 39	42.28	(104)	-------	-------	57.77	(142)
40 - 49	26.22	(59)	-------	-------	73.78	(166)
50 - 59	15.93	(36)	-------	-------	84.07	(190)
60 - 69	11.66	(21)	-------	-------	88.34	(159)
70 - 79	3.33	(3)	-------	-------	96.67	(88)
80 +	0.00	(0)	-------	-------	100.00	(25)
Colored Women						
20 - 29	51.54	(151)	-------	-------	48.46	(142)
30 - 39	45.16	(98)	-------	-------	54.84	(119)
40 - 49	32.35	(55)	0.59	(1)	67.06	(114)
50 - 59	18.01	(29)	0.62	(1)	81.37	(131)
60 +	6.48	(9)	2.16	(3)	91.36	(127)

aganda by the cigarette makers during the last quarter century. The percentage of non-smoking men increases steadily above age 50, and of non-smoking women above age 40. The smoking statistics in Columbus were also segregated into 3 city zones: (1) Cleanest suburban areas, (2) intermediate districts and (3) the downtown and industrial districts of greatest air pollution. Such zoning also gave a rough division of the population on an economic basis. These detailed statistics will be published elsewhere.[2]

PULMONARY TUBERCULOSIS AND SMOKING HABITS

Information on smoking habits was obtained on 517 white male and 300 white female patients above age 20, from the records of the Dunham Hospital for tuberculosis in Cincinnati. These patients were in very large part charity cases from the poorer sections of the city, and hence comparison is made with corresponding age groups from the poorest section of the Columbus population.

In deriving the Columbus control groups on smoking habits for comparison with the smoking habits of the various groups of disease victims listed in this paper, special care was taken to see that the control group had exactly the same age distribution (decade by decade) as the disease group with which comparison was being made. This was not done by picking out the required number of Columbus individuals from each age decade, but rather by taking the proper percentage of the whole age decade group.

As seen in table 3 the incidence of cigarette smoking is definitely and significantly higher in both male and female tuberculous patients than among appropriate Columbus controls. Since it is scarcely conceivable that men or women would take up smoking because they have tuberculosis, we must conclude that smoking probably predisposes to the initiation of this disease or to the likelihood that minimal infection will progress to a clinically active stage.

CANCERS OF MOUTH AND RESPIRATORY TRACT IN RELATION TO SMOKING HABITS

Information on smoking habits was obtained from next of kin, by interview or questionnaire, for some 175 such white male cancer victims dying in Cincinnati during the years 1940 to 1945

TABLE II

Age	WHITE MEN Cigarettes or Combinations thereof		Pipe and/or Cigars		COLORED MEN Cigarettes or Combinations thereof		Pipe and/or Cigars	
	%	No.	%	No.	%	No.	%	No.
20 - 29	74.93	(263)	2.28	(8)	78.54	(194)	3.64	(9)
30 - 39	74.21	(141)	3.68	(7)	76.34	(142)	10.75	(20)
40 - 49	76.20	(143)	13.89	(30)	68.04	(132)	18.04	(35)
50 - 59	59.04	(111)	16.49	(31)	58.28	(102)	22.86	(40)
60 - 69	42.50	(51)	22.50	(27)	28.19	(42)	42.95	(64)
70 - 79	18.84	(13)	24.64	(17)	(Includes all over age 60)			
80 +	5.26	(1)	47.37	(9)				

TABLE III

PULMONARY TUBERCULOSIS AND TOBACCO SMOKING

Group	Number of cases	Mean age	Incidence of Smoking: Cigarettes Only	Pipe, Cigars or Combinations	Non-smokers
			% PE	% PE	% PE
White male patients	517	43.8	76.60±1.26	8.51±0.83	14.89±1.05
Columbus controls	777	43.8	56.24±1.20	19.56±0.96	24.20±1.04
Diff./PE diff.			20.36 / ±1.74 = 11.7	11.05 / ±1.27 = 8.7	9.31 / ±1.48 = 6.3
White female patients	300	34.1	47.67±1.94		52.33±1.94
Columbus controls	600	34.1	36.00±1.32		64.00±1.32
Diff./PE diff.			11.67 / ±2.35 = 5.0		11.67 / ±2.35 = 5.0

and for 394 dying in Detroit from 1942 to 1946 inclusive. Comparison was made with the smoking habits of white men of similar mean age from the whole of Columbus, with results published elsewhere.[2]

An abnormally high incidence of cigar and pipe smoking was found among male cancer victims of both upper and lower air passages, together with a significantly low incidence of non-smokers. Among victims of buccal cancers, cigarette smoking habits were practically normal, but there was found a definite and significant increase of cigarette smoking among victims of lower respiratory tract cancer (from the larynx down).

The markedly abnormal percentage of cigar and pipe smokers among both groups of cancer victims was especially interesting, in view of the fact that more sluggish combustion in these types of smoking gives rise to more of the irritating tarry materials demonstrated to be freely cancerigenic for susceptible animals. Roffo[3] found that 95 per cent of all respiratory tract cancers occurred in smokers, while in our series here detailed 93 per cent were smokers (90 per cent among the buccal cancer victims).

PNEUMONIA AND TOBACCO SMOKING

Smoking habits were obtained for 60 white male pneumonia victims dying during 1945-1947 in Cincinnati and on 58 others treated for pneumonia in the General Hospital, and comparison made with appropriate age controls among Columbus men (table 4).

Even with this small series, pneumonia victims show significantly more addiction to cigarette smoking than is found in appropriate normal control groups. Morton[4] found postoperate pneumonia 6 times more frequent among smokers than among non-smokers following general gaseous anesthesia.

CORONARY OCCLUSION DEATHS AND TOBACCO SMOKING

Smoking habits were obtained on 484 white men dying of coronary occlusion in Cincinnati during 1946 and 1947, and comparison made with appropriate age controls among Columbus men as listed in table 2.

All male coronary victims under 41 years of age were cigarette smokers and all but 1 under 46 years! The percentage of cigarette smokers among coronary victims is significantly higher than normal up to age 60, while after this age the incidence of pipe and cigar smoking is abnormally high (table 5). Tobacco smoking in some form is thus abnormally prevalent among all ages of coronary victims and the percentage of non-smokers significantly below normal. The great increase in cigarette smoking during recent decades, especially among younger age groups, no doubt accounts for the age differences in dominant smoking types here observed.

TOBACCO SMOKING HABITS IN PEPTIC ULCER VICTIMS

Medical opinion has long held that peptic ulcer patients should abstain from tobacco smoking. This is particularly true for cigarette smoking, in which rapid absorption from the lungs and direct distribution to peripheral tissues without detoxification in the liver produces maximal

TABLE IV

PNEUMONIA AND TOBACCO SMOKING
(White Males Only)

Group	Number of Cases	Mean Age	Incidence of Smoking: Cigarettes Only	Pipe, Cigars or Combinations	Non-smokers
			% PE	% PE	% PE
Pneumonia cases	118	49.6	63.56±2.98	21.19±2.52	15.25±2.23
Columbus controls	472	49.6	52.33±1.54	22.46±1.29	25.21±1.34
Diff./PE diff.			11.23 / ±3.35 = 3.3	1.23 / ±2.83 = 0.4	9.96 / ±2.60 = 3.8

TABLE V

SMOKING HABITS AMONG CORONARY VICTIMS
(White Males Only)

Groups	Number of Cases	Ages	Incidence of Smoking: Cigarettes*	Pipe and/or Cigars	Non-smokers
			% PE	% PE	% PE
Coronary	2	20-29	100	0	0
Controls	351	20-29	74.93	2.28	22.79
Coronary	8	30-39	100	0	0
Controls	190	30-39	74.21	3.68	22.11
Coronary	56	40-49	83.93±3.30	8.93±2.58	7.14±2.30
Controls	216	40-49	70.83±2.08	9.26±1.31	19.91±1.84
Diff./PE diff.			13.10 / ±3.90 = 3.4	0.33 / ±2.89 = 0.1	12.77 / ±2.95 = 4.3
Coronary	135	50-59	82.23±2.23	11.11±1.81	6.66±1.38
Controls	188	50-59	59.94±2.42	16.49±1.80	24.47±2.10
Diff./PE diff.			23.19 / ±3.29 = 7.1	5.38 / ±2.65 = 2.0	17.81 / ±2.51 = 7.1
Coronary	153	60-69	49.02±2.72	32.68±2.56	18.30±2.10
Controls	114	60-69	43.86±3.13	21.05±2.57	35.09±3.01
Diff./PE diff.			5.16 / ±4.15 = 1.2	11.63 / ±3.63 = 3.2	16.79 / ±3.67 = 4.6
Coronary	130	70+	18.46±2.27	47.69±2.96	33.84±2.80
Controls	88	70+	16.47±2.63	29.41±3.26	54.12±3.58
Diff./PE diff.			1.99 / ±3.47 = 0.6	18.28 / ±4.40 = 4.2	20.28 / ±4.54 = 4.5

* Any smoking combination which included cigarettes.

nicotinic effects on autonomic ganglion cells. Nicotine gaining entrance by way of the gastroenteric tract, on the other hand, faces considerable detoxication in the liver before being distributed generally to body tissues. Tobacco chewing is thus least associated with peptic ulcer incidence, pipe and cigar smoking comes next, while cigarette smoking is overwhelmingly prevalent in male ulcer victims.

Tyrell-Gray[5] in 1924 reported a tobacco smoking incidence of 96 per cent among male ulcer patients, and Trowell[6] in 1934 a 92 per cent incidence (90 per cent cigarette). Jamieson, et al.,[7] reported more severe symptoms among heavy cigarette users and milder symptoms with lighter cigarette use among 451 male peptic ulcer patients, no such association being present among pipe or cigar smokers. Wilkerson[8] insists that peptic ulcer patients must not smoke, if effective treatment is to be expected.

It is of interest, therefore, to find that 97 per cent of our 30 white male peptic ulcer victims below 60 years of age were tobacco smokers, (all but 2 smoked cigarettes). Beyond 60 years of age the tobacco smoking habit of 25 ulcer victims showed no significant deviation from normal. Below age 50, all 17 victims were cigarette smokers. The 55 cases in table 6 were those for whom tobacco smoking habits were obtained from among some 87 questionnaires sent out to next of kin of those dying from this cause in Cincinnati during 1946 and 1947.

TOBACCO SMOKING HABITS AND BREAST FEEDING OF INFANTS

The past has seen much controversy but little real evidence as to whether tobacco smoking interferes with a mother's ability to nurse her child. A survey of American obstetricians[9] elicited a general condemnation of excessive smoking during the latter months of pregnancy and the nursing period. These were only opinions, however, without statistical support. Pearlman et al.[10] did publish findings which suggested an improvement in nursing

TABLE VI

SMOKING HABITS AMONG PEPTIC ULCER VICTIMS
(White Males Only)

Group	Number of Cases	Mean Age	Incidence of Smoking: Cigarettes*	Pipe and/or Cigars	Non-smokers
			% PE	% PE	% PE
Peptic ulcer	55	60.1	64.64±4.34	18.18±3.51	18.18±3.51
Columbus controls	275	60.1	45.45±2.02	19.64±1.61	34.91±1.94
Diff./PE diff.			19.19 / ±4.79 = 4.0	1.46 / ±3.86 = 0.4	16.73 / ±4.01 = 4.2

* Any smoking combination which included cigarettes.

TABLE VII

SMOKING HABITS AND BREAST FEEDING

Month of Delivery	Number of Cases	Smoking Mothers		Non-smoking Mothers	
		Percentage	Mean Nursing Period	Percentage	Mean Nursing Period
			Mo. PE		Mo. PE
January	244	39.75±2.11	2.43±0.21 (82)	60.25	3.23±0.19 (120)
August	276	42.75±2.01	2.27±0.17 (95)	57.25	2.91±0.20 (129)
Jan. & Aug.	520	41.35±1.45	2.34±0.13 (177)	58.65	3.06±0.13 (249)
Special*	24				3.04±0.48 (24)

* 24 smokers who abstained for over three months before delivery, (12 in January group and 12 in August group).

ability with increasing degrees of cigarette smoking, but their numbers of cases were inadequate to establish the validity of such conclusions.

Inhalation of tobacco smoke by pregnant female rabbits[11] led to an abnormally high stillbirth rate and a small birth size of the young, with only one-third the normal number living on to maturity. There were even hints that these effects held on into the second and third generations of offspring from such damaged individuals, without further exposure to smoke. Any such lasting effects would indicate a degree of smoke exposure probably beyond that experienced by human beings.

In order to obtain stable statistical evidence as to the effects of smoking on ability to nurse, some 2500 white women giving birth to their first living offspring in Cincinnati during January and August, 1947, were questioned as to smoking habits during pregnancy and the nursing period. The study was limited to white women 18 - 29 years of age so as to minimize the statistical variables, and the two months of January and August were chosen to bring out possible seasonal differences in nursing ability. Replies were received from 520 of these mothers, with the results here briefly summarized. (Table 7.)

No nursing data were obtained on 3 smokers and 27 non-smokers in the January group and on 11 smokers and 29 non-smokers in the August group. One item on the questionnaire was "Did you desire to nurse this baby?" Where the answer to this question was "no" and the indicated nursing time not over ten days, the case was discarded on the grounds of uncertainty. In cases without desire to nurse but with a history of nursing on beyond ten days, it was considered that the indicated nursing history really represented the ability to nurse.

There are several points of interest in the data set forth in table 8. In the first place, the percentage of smokers in the whole group of 520 is 41.35, differing quite insignificantly from the 39.6 per cent smokers among Columbus white women 20 to 29 years of age. In the second place, both smoking and non-smoking mothers nursed their August-born babies for slightly shorter periods than was the case with the January-born. While these differences are not mathematically significant, their uniformity is strongly suggestive of a seasonal influence in favor of January delivery. The differences in length of nursing periods (between smokers and non-smokers) are in every case in the realm of probable significance, being over twice their own probable errors. With the combined January-August group, the difference is 3.7 times its own probable error.

Greatest interest, however, attaches to the group of 24 smoking mothers who abstained during the last 3+ months of pregnancy. The mean nursing period for these 24 habitual smokers was almost identical with that exhibited by the non-smokers. While the differences in nursing ability exhibited by the various groups are not as clear-cut and significant as one would desire, it does seem that smoking introduces a nursing handicap.

There was no significant difference between smoking and non-smoking mother groups in total inability to nurse the offspring. Among all mothers nursing their babies on to 2 months and beyond, however, the mean nursing period was definitely longer for the non-smokers, (5.78±0.18 months as compared to 4.01±0.30). Only 36 per cent of the smokers continued the nursing to 2 months or beyond while 46 per cent of the non-smokers did so (28 per cent of the non-smokers carried the nursing on to 4 months or more, while only 16 per cent of the smokers did as well). It would thus seem that the principal nursing handicap encountered by mothers who smoke is not a total inability to nurse, but rather an inability to continue the nursing function on the normal number of months.

ACTIVE INVESTIGATION OF OTHER MATERNAL SMOKING INFLUENCES

We are still actively investigating the relationship of maternal smoking to the birth of malformed infants, to stillbirths, and to the increasing number of infants who develop hypertrophic pyloric stenosis (constriction of outlet of stomach). Malformations and pyloric stenosis are both definitely increasing in incidence, nor has medical science much evidence as to their cause. Swan and co-workers in Australia[12] made the startling discovery that German measles in the mother during the early months

of pregnancy caused a very marked increase in the percentage of malformed infants. Warkany[13] has shown equally marked effects on animals by feeding diets deficient in certain vitamins.

To date our own findings indicate that smoking mothers are more likely to give birth to malformed infants and to those who develop pyloric stenosis in the first month of life. Stillbirths are only slightly more prevalent among smoking than non-smoking mothers. Since absorbed nicotine would be only one of the many abnormal factors disturbing foetal development, we will consider it of considerable importance if we find differences even in the lower ranges of significance.

DISCUSSION

Almost every tobacco novice is familiar with the acute effects of nicotine poisoning,—the nausea, vomiting, abdominal cramps, diarrhea, blurring of vision, clammy perspiration and prostration of varying degree. Although amusing to the onlooker, these symptoms of ganglionic cell poisoning mean intense misery for the victim. Few people realize, however, that this passing discomfort from absorbed nicotine might often be only a feeble forerunner of more profound and fatal effects down through the years of tobacco usage. Nicotine is a powerful drug, with a characteristic action (stimulative-irritative-paralytic) on ganglion cells of the nervous system, particularly those of the involuntary or autonomic nervous system. Its action is indeed so characteristic that all other drugs exerting a similar effect are said to have a "nicotinic" action.

Some years ago Raymond Pearl[14] found the life span to be significantly shorter for smokers than for non-smokers, without limiting the effect to any one cause of death. Now we begin to see the disease groupings in which tobacco smoking may be an important factor. In the air passages themselves, tobacco smoke irritation is significantly associated with the same three killing respiratory diseases already linked so closely with outdoor air pollution. The excessively high rates for these diseases among men of dirty urban areas may well be due to a pyramiding of effects of the two forms of air pollution.

It is well recognized that only tobacco smokers are afflicted with thromboangeitis obliterus, which causes so much trouble by cutting off circulation to the extremities, and that no treatment will be successful unless the habit is given up completely. Wise physicians also have become increasingly suspicious of nicotine's baneful influence in the rise of heart and vessel diseases to first rank among the causes of death in man. Certainly the statistics here set forth will in no way allay these suspicions. The association is equally close between smoking and peptic ulcer or respiratory tract cancers.

Most disturbing of all, however, is the possibility that smoking by women in the childbearing period may seriously interfere with normal reproductive functions and lactation. This is a subject of paramount importance to the race and is now being closely investigated.

There seems to be an abundance of hints of biologic damage from tobacco smoking in both men and women. For many the habit is a difficult one to break, hence the importance of steps to prevent its beginning. This will be difficult, so long as it is considered the mark of the blasé and sophisticated individual. Nor will it be easy to discourage smoking among children when their mothers habitually indulge. Precept is never so potent as example in child-rearing.

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Nausea and Vomiting

The mechanism of nausea and vomiting in the first trimester remains obscure. Indirect approaches have been made recently by Dorsey, and Bertling and Burwell. Dorsey uses pyridoxine 25 mgm. and adrenal cortex extract (Upjohn and Armour) one-half cc. in two injections 24 hours apart; subsequent injections are given in 3 to 5 days as needed. Among 30 primiparas and 32 multiparas, there were 3 failures, complete relief in 56, and marked improvement in 3—an incidence of 95.1 per cent success. Bertling and Burwell report 4 per cent failures, 70 per cent complete relief and 26 per cent improvement among 31 patients treated with stilbestrol in doses of 5 mgm. daily.—G. A. Mitchell, M. D., J. Tenn. S. M. A., 43:315, 1950.

Saline Solution in Treatment of Burn Shock

THE Surgery Study Section of the National Institutes of Health has recommended to the Surgeon General of the Public Health Service that the use of oral saline solutions be adopted as standard procedure in the treatment of shock due to burns and other injuries in the event of large-scale civilian catastrophe.

The recommendation followed action taken at the January 1950 meeting of the Surgery Study Section, when such treatment was approved in principle. Dr. Carl A. Moyer, a member of the Study Section, was designated at that time to prepare a memorandum suitable for submission to Dr. Norvin A. Kiefer, Director, Health Resources Division (now Health Resources Office), National Security Resources Board.

Dr. Moyer's memorandum, which was submitted to Dr. Kiefer, February 15, 1950, reads as follows:

"Since the publication of the experimental work of Dr. Rosenthal, Dr. Coller, et al., orally administered salt solutions have been employed in the treatment of burns at the University of Michigan Hospital, Ann Arbor, Mich.; at the Wayne County General Hospital, Eloise, Mich.; and at Parkland Hospital, Dallas, Tex. Personal clinical experience, in the above-named hospitals, has convinced me that the orally administered salt solutions are valuable adjunctive agents in the treatment of shock incident to burns, fractures, peritonitis, and acute anaphylactoid reactions. Certain factors are important in governing the effectiveness of the oral administration of salt solutions. They are as follows:

IMPORTANT FACTORS

"1. The composition of the salt solution: The most palatable salt solution is made by dissolving 3 to 4 grams of sodium chloride and 2 to 3 grams of sodium citrate in each liter of water. If sodium citrate is not available, ordinary baking soda may be substituted for it.

"2. The concentration of salt should not be in excess of 140 milliequivalents of sodium per liter. If the concentration is above this, vomiting and diarrhea became important complicating factors.

"3. Whenever profound peripheral circulatory collapse is present, the intravenous route of administration must be used until peripheral blood flow has been reëstablished. The salt solutions that we have found most satisfactory for this purpose are Hartmann's solution (Lactate-Ringer's solution) or plasma. In addition to the salt solution or plasma intravenously, whole blood is given concurrently whenever peripheral circulatory collapse exists. This materially implements the effectiveness of salt solutions.

"The slightly hypotonic salt solution is the only drinking fluid permitted the injured individual until the edema of the injured parts begins to subside. Certain exceptions to this rule have to be made during the hot weather of summer when it is sometimes necessary to permit the partaking of some non-salty water.

"As much as 10 liters of the hypotonic salt solution have been drunk in the 24-hour period by adults who have been severely burned. Since salt solution has been substituted for water, as a drinkable fluid, no burned person who has lived for longer than 3 hours after being admitted to the hospital has suffered from anuria. The 'early toxemia phase' of the burns has also failed to appear and the osmotic concentration of the plasma electrolytes has been well maintained.

MORE WORK NEEED

"We feel that much more clinical observation and actual experimental work should be undertaken regarding the effectiveness of the basic principles of the supportive therapy of burns that have been so beautifully demonstrated by Dr. Rosenthal. It is obvious that the adoption of a more active program of investigation into the relative effectiveness of simple measures to combat shock would be of extreme importance to the Armed Forces and to the civilian population in the event of another war."

Because of the sharpened national emergency that developed during the summer of 1950, the Surgery Study Section, in approving Dr. Moyer's

Editor's Note:

● **In submitting the accompanying article, Dr. Leonard A. Scheele, Surgeon General, U. S. P. H. S., made the following statement:**

"I would invite your attention to the very important fact that this recommendation will in no sense decrease the need for whole blood, and must not be construed as lessening in any way the importance of blood bank programs. It is our considered opinion, however, that information on sodium treatment might well be included immediately, as an emergency procedure, in first aid training programs."

● **The Editor concurs in the recommendation of the Surgery Study Section as well as in the statement made by Dr. Scheele.**

Submitted Oct. 14, 1950.

memorandum at its meeting on September 16, changed the last paragraph to read:

"While further clinical research concerning the effectiveness of oral salt solution in the treatment of burns and other injuries is certainly in order, there is already sufficient evidence to suggest that this form of treatment should be used in any large-scale disaster involving the civilian population."

The Surgery Study Section letter to the Surgeon General, dated September 16, 1950, reads as follows:

TEXT OF LETTER

"It is my understanding that one of the functions of the Study Sections is to offer advice to the Surgeon General in fields of medicine lying within the special competence of the Study Section members. At the January 1950 meeting of the Surgery Study Section, there was considerable discussion concerning the use of oral saline solutions in the treatment of burns and other serious injuries. It was the consensus of the Section at that time that, on the basis of the animal work which had been done by Dr. Rosenthal of the National Institutes of Health, and the clinical work which had been done by Dr. Carl A. Moyer, by the undersigned, and by others, the efficacy of such treatment had been definitely demonstrated and that, while there is need to stimulate additional research in this field, our present knowledge is sound enough so that action can be taken on this basis. Dr. Moyer was designated to draft a short memorandum expressing our point of view on this subject. Such a memorandum was prepared and furnished to Dr. Norvin C. Kiefer, Director, Health Resources Division, National Security Resources Board, on February 15, 1950. A copy of Dr. Moyer's memorandum is attached.

"In view of the more acute national emergency that has developed since Dr. Moyer wrote this memorandum, the Study Section, at its meeting on September 16, 1950, voted to recommend that the principles of treatment outlined in his memorandum be adopted for widespread use in any large-scale disaster involving the civilian population. Because of the present emergency situation, we have modified the last paragraph of Dr. Moyer's memorandum to read, 'While further clinical research concerning the effectiveness of oral salt solution in the treatment of burns and other injuries is certainly in order, there is already sufficient evidence to suggest that this form of treatment should be used in any large-scale disaster involving the civilian population.'

"You are at liberty to transmit this recommendation of the Surgery Study Section to the National Security Resources Board or to other proper agencies, and, if you see fit, to publish it. We feel strongly that it is important for the medical profession of the country and for those planning for the handling of potential disasters to be informed of the value of this simple and easily carried out form of treatment."

THOSE SIGNING

The letter was signed by Frederick A. Coller, M. D., University of Michigan, Chairman of the Surgery Study Section. Members of the Study Section, in addition to Dr. Coller, are: Dr. Claude S. Beck, professor of neurosurgery, Western Reserve University; Dr. Loren R. Chandler, dean, Stanford University Medical School; Dr. Lester R. Dragstedt, professor of surgery, University of Chicago; Dr. Daniel C. Elkin, professor of surgery, Emory University; Dr. Carl A. Moyer, dean and professor of surgery, Southwestern Medical School, University of Texas; Dr. Harris B. Shumacker, Jr., professor of surgery, Indiana University Medical Center; Dr. Owen H. Wangensteen, professor of surgery, University of Minnesota; Dr. Allen O. Whipple, clinical director, Memorial Hospital, New York Owen H. Wangensteen, professor of surgery, Staten Island Marine Hospital; Dr. Henry Beecher, professor of anesthesiology, Harvard University Medical School; Dr. J. Gordon Lee, chief of surgery, Mount Alto Hospital, Washington, D. C.; Dr. Howard R. Lawrence, chief of surgery, Francis E. Warren Air Force Base Hospital, Wyoming; and Dr. G. Halsey Hunt, Chief, Division of Hospitals, Public Health Service.

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Superior Vena Cava Obstruction Due To Chronic Mediastinitis and Phlebitis

SALVATORE M. SANCETTA, M.D., and HAROLD E. McDONALD, M.D.

CHRONIC mediastinitis with compression of the superior vena cava, with or without secondary intraluminal thrombosis, is the third or fourth most common cause of obstruction of this vessel. In the case which is the subject of this report, chronic mediastinitis was present, but rather than compression of the vessel, necropsy revealed a replacement of the vessel wall and almost complete obliteration of the lumen by a process indistinguishable from the mediastinal involvement.

REPORT OF CASE

A fifty-year old colored female was admitted to the Medical Service, Cleveland City Hospital, on March 7, 1949. with the complaints of progressive dyspnea, and swelling of the neck, face and upper extremities of five weeks' duration. She had worked as a housekeeper most of her life, and in the past three years had been employed as a ward aide on the psychiatric service. She had had pneumonia in childhood, and in the past five years had suffered five to six episodes of upper respiratory infections yearly, characterized by severe, scantily productive cough. Four years previously a moderate arterial hypertension was found. Two years before admission she was kicked on the upper sternum by a patient, but suffered no apparent immediate after effects. A chest film at this time revealed no abnormalities other than a minimal inactive tuberculous right subapical lesion. Follow-up films revealed no change including the most recent X-ray in October of 1948.

In December 1948 she developed two severe bouts of acute upper respiratory infection, the latter terminating in mid-January 1949. A moderate non-productive cough persisted. About February 1, 1949, she noticed dyspnea which increased progressively in severity, orthopnea, and slight swelling of the neck and supraclavicular fossae. Within four weeks marked edema of the entire face and of the upper extremities supervened. She developed hoarseness, the dyspnea became disabling, and she was admitted into the hospital.

Physical Examination. The patient was an alert and obese negro female who was moderately dyspneic. The temperature was 37.2 degrees C., the respiratory rate 28, the pulse rate 72, and the blood pressure 205/112 and 174/112 in the right and left arms respectively. The lips and nail beds were cyanotic. The face, neck, and supraclavicular fossae were uniformly swollen and firm. The parotid and submandibular glands were enlarged and non-tender. There was moderate edema of both upper extremities. The jugular veins were distended and did not visibly change in caliber on inspiration and during the performance of Valsalva's experiment. Over the thorax were numerous dilated veins which filled from above. The veins of the fundi were engorged with blood, but the arterioles were normal. The heart was normal. The remainder of the physical examination was within normal limits.

Laboratory Work. Examinations of the blood and urine were normal. The blood serology was negative. The electrocardiogram was normal. A six foot posteroanterior view of the chest showed a minimal widening of the upper right mediastinal shadow. The venous pressure in the anti-cubital veins was 41 centimeters of water and in the femoral veins 7 centimeters of water. The venogram was made by injecting 70 per cent diodrast® into the left median cubital vein (figure 1). An attempt at bronchoscopy was unsucessful because of the marked edema of the pharynx and neck.

Hospital Course. Phlebotomy was followed only by transient relief of dyspnea, which progressed rapidly in severity.

Both the angiograms and the presence of surface collaterals favored the view that the azygos vein was involved. Because of the rapid progression of symptoms it was felt that exploratory thoracotomy was warranted in the hope of finding a chronic mediastinitis and performing a lysis to relieve the compression. On entering the superior mediastinum the superior vena cava had to be freed by blunt and sharp dissection from the dense enveloping fibrous tissue. The vessel felt firm and fibrotic from the innominate junction to the pericardial reflection. Since this defect could not be bridged nothing further was attempted. The patient expired shortly after being returned to the ward.

Gross Pathology. The only significant abnormal findings were within the thorax. 100 cubic centimeters of bloody fluid were present within the right pleural cavity. The pericardial sac contained 75 cubic centimeters of chylous fluid. The mediastinal tissues were distorted

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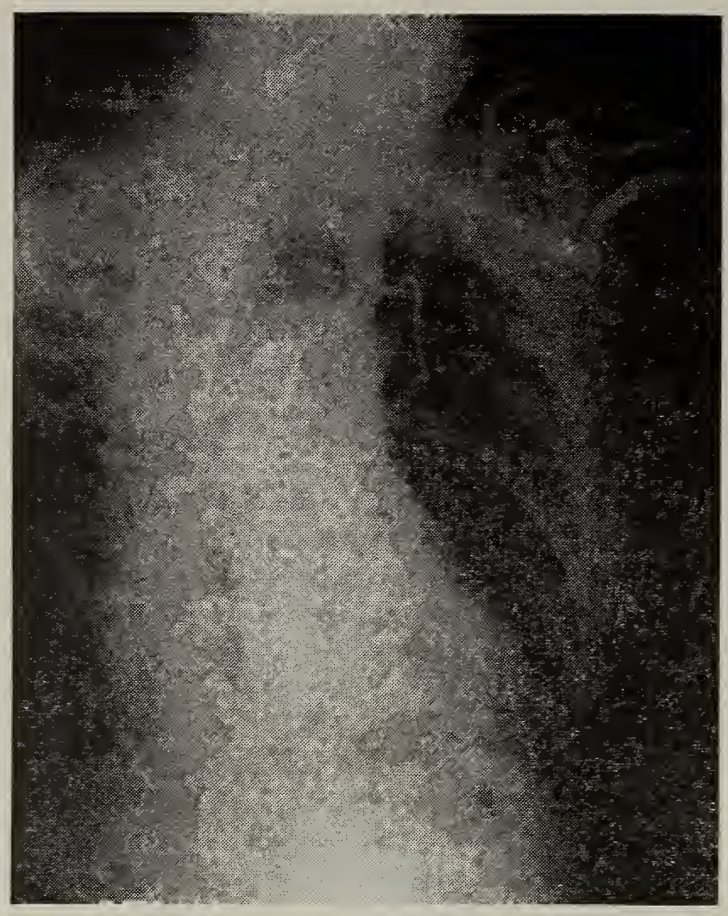


Fig. 1. Right oblique roentgenogram of the chest taken during diodrast visualization of venous return to the heart. Note the marked narrowing of the superior vena cava and the increased venous circulation about the left shoulder girdle.

by much recent hemorrhage. The superior vena cava had been partially surgically freed from the thick, enveloping fibrous tissue. 1.5 centimeters above the entrance into the right auricle the vessel wall became thickened, hard and inelastic. This change extended from this point to the junction of the innominate veins, the involved vessel measuring 5 centimeters in length and 2.5 centimeters in diameter. Multiple transverse sections revealed firm homogeneous yellowish gray cut surfaces. The remaining lumen was eccentric and narrowed to 0.5 by 0.2 centimeters in its smallest diameters, gradually widening at both proximal and distal ends (figure 2). In the middle 2 centimeters of the length of the superior vena cava it was impossible to find a line of demarcation between the adventitia of the vessel and the surrounding mediastinal tissue. In the hilus of the right lung was a discrete lymph node measuring 1.5 x 1 x 0.5 centimeters, which on section revealed soft, yellow caseous material. The remaining lymph nodes appeared grossly normal. Although the right main stem bronchus, the esophagus and the medial aspect of the right upper lobe were adherent to each other by this fibrotic process, there was no evidence of compression of these structures.



Fig. 2. Cross section of the superior vena cava midway between the right atrium and the innominate junction. The specimen has been laid apart to show the contiguous cut surface. The small, roughly cut triangular remnant of the lumen is shown in the upper and lower right hand corners.

Microscopic Pathology. Sections of the superior vena cava showed only a small, slightly thickened segment of the vein wall in which the architecture was recognizable. The remainder of the wall was replaced by interlacing and whorled bundles of collagen and fibrous tissue, with only a few scattered fibroblasts. The junction with the slightly thickened vessel wall was diffusely and densely infiltrated with lymphocytes and plasmacytes. In some situations the fibrous bundles formed small fusiform spaces, while in others there were large, dilated, endothelialized spaces with a moderate surrounding infiltration of lymphocytes and plasmacytes. Scattered irregularly throughout were focal collections of similar cells, while in other situations a fine fibrous stroma was similarly diffusely infiltrated. The microscopic appearance was that of a non-specific granulomatous process without foreign body reaction. The lumen of the superior vena cava was eccentrically distorted by the fibrous tissue to a narrow slit. The adventitia could not be positively identified. Sections of the fibrous tissue surrounding the vein showed changes similar to those described above. Masson, T.P.H., and reticulum stains showed no stromal elements other than fibrous tissue and collagen; iron stains were negative.

DISCUSSION

Two excellent reviews of the subject of superior vena cava obstruction have appeared within the last year, those of Hinshaw[2] and of McIntyre and Sykes.[3] The latter is comprehensive and complete. The authors reviewed all the reliable cases reported to date.

Approximately 35 per cent of cases of obstruction of the superior vena cava are due to compression by tumor, 24 per cent by aortic aneurysm, and 10 per cent by chronic fibrous mediastinitis, the etiology of the latter being in considerable doubt. In the course of such fibrosis, obstruction is due to mere compression or secondary caval thrombosis, whether this be purely mechanical or associated with local phlebitis. The unusual feature in this case was the apparent lack of compression of the vein and the absence of thrombosis. The vessel wall had been in great part replaced by tissue identical to that surrounding the vein and the lumen almost completely obliterated by similar endothelialized tissue. The latter was exactly the

same as the photomicrographs reproduced in the report of Erganian and Wade.[1]

Ultimate diagnosis of the mechanism of obstruction in upper caval compression rests entirely on roentgenologic techniques followed by exploratory thoracotomy. Failure to visualize a mass points strongly to primary caval thrombosis or fibrous mediastinitis, where often little is seen in the chest film but a slight, diffuse hazy widening of the upper mediastinal shadow. Angiocardiography aids in judging the extent of obstruction and furnishes the surgeon with the proper choice of the operative site. With some exceptions, exploratory thoracotomy is indicated. The latter procedure is no longer considered to be as formidable as it once was, and unlike this case, it is possible in some instances to remove the ensheathing fibrous mass with good results.

SUMMARY

A case of superior vena cava syndrome due to chronic fibrous mediastinitis is presented in which there was neither compression nor thrombosis of the vessel, but rather a replacement of the wall and almost complete obliteration of the lumen by collagen and fibrous tissue identical to that surrounding the vein.

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Classification of Cervical Cancer

The proposed modification of the classification of cervical cancer follows:

Stage O

Carcinoma *in situ*—also known as preinvasive carcinoma, intra-epithelial carcinoma and similar conditions.

Stage I

The carcinoma is strictly confined to the cervix.

Stage II

The carcinoma extends beyond the cervix, but has not reached the pelvic wall. The carcinoma involves the vagina, but not the lower third.

Stage III

The carcinoma has reached the pelvic wall. (On rectal examination no "cancer-free" space is found between the tumor and the pelvic wall.)

The carcinoma involves the lower third of the vagina.

Stage IV

The carcinoma involves the bladder or the rectum, or both, or has extended beyond the limits previously described.

The Effects of Glove Powders on the Eye

The possibility of accidental instillation of glove powder into the eye from unrinsed or punctured gloves must be considered. Experimental studies have been made which demonstrate the harmful effects of magnesium silicate (talcum powder) in general surgery. Chamlin has shown the harmful effects of the same powder in the eye. Recently other substances have been used in general surgery as glove powders which do not have these effects. They are potassium bitartrate and a modified starch preparation known commercially as biosorb. This study was made to compare the effects of these newer substances with talc in order to determine which is the safest for ophthalmic surgery.

Various amounts of the powders were instilled into the anterior chamber of rabbits' eyes and injected beneath the extraocular muscles of the same animals. The rabbits were observed for a period of three weeks when the eyes were enucleated.

GROSS FINDINGS—A ten per cent suspension of talcum powder in water when injected beneath one extraocular muscle produced a moderately severe inflammation which persisted the entire period of observation. The same concentration of potassium bitartrate and biosorb did not cause as severe an inflammation of the tissues and in each of these, there was a gradual resolution of the inflammatory process.

0.1 cc. of a 1 per cent suspension of talc, when injected into the anterior chamber, tended to collect as granular deposits on the iris which was practically absorbed in three weeks. No gross changes could be seen after one week from potassium bitartrate in the same dosage. When .03 per cent mixtures of the same preparations were used, no gross changes were observed in any case.

HISTOLOGICAL FINDINGS—Sections of the eyes enucleated after the three-week period were examined for microscopic changes. These will be reported in detail.

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Pittsburgh, Pa.

Brief authors' abstract of paper presented at charter session of the Association for Research in Ophthalmology, East-Central Section, held in Cleveland, Jan. 10, 1950.

Absolute five-year survival figures on ninety-nine consecutive cervix cancer patients treated by x-ray and radium prior to 1944 show a survival rate of 50.5 per cent. In the obese woman, the survival rate declines to a 37 per cent average. —R. C. Hildreth, M. D., Kalamazoo, Mich.; The Journal of the Michigan State Medical Society; Volume 49, Number 10, October, 1950.

Accidental Vaccination: Report of Three Cases in Adults With Severe Generalized Vaccinia in One Case

HARRY WAIN, M. D., and WALLACE H. BUKER, M. D.

ACCIDENTAL vaccination is the condition which results from the chance or accidental inoculation or contamination of a non-immune person with the virus of vaccinia. In view of the large number of vaccinations that are performed, accidental vaccinations, while not rare, are uncommon. Their mode of occurrence may be of two types: (1) Auto-inoculation, in which there is direct transfer of the virus from the site of vaccination to other portions of the anatomy; and (2) Hetero-inoculation, in which the virus is accidentally transferred from a newly vaccinated person with an active primary vaccinia to some other person.

The importance and danger of accidental vaccination depends primarily on the site. A review of the literature reveals that one of the most frequent locations is the region about the eyes, and cases are reported of inoculation occurring on the cornea with resulting blindness. Vaccinations occurring on the face may be quite disfiguring.

The lips, nose, tongue and genital organs all have been reported as sites of accidental inoculation and frequently present a serious and confusing diagnostic problem.

Numerous reports are found in the literature of physicians having had the unpleasant experience of developing vaccinia lesions on the fingers and thumbs as the result of performing vaccinations.

Trommer in the March 20, 1943, issue of *The Journal of the A. M. A.* advises physicians to tape their thumbs with adhesive and to wear rubber gloves so as to prevent alcoholic dehydration and auto-inoculation of the fingers when performing mass vaccinations. In addition all physicians should be sure of their own immunity to smallpox.

A RARE BUT SERIOUS COMPLICATION

Generalized vaccinia is the term applied to the generalized eruption of typical vaccinal lesions occurring after vaccination. It varies in degree from a mild illness with a few scattered lesions to a severe fatal infection with a clinical course similar to that of smallpox. It is a rare but serious complication of vaccination and reliable surveys place the incidence at 1 in 20,000 to 1 in 40,000 vaccinations with a case fatality rate of 12 to 30 per cent. About two-thirds of the persons in whom this complication occurs have skin diseases and most of these are infants or children with an atopic dermatitis.

Generalized vaccinia in persons with an atopic dermatitis or eczema has been called eczema vaccinatum. Clinically similar conditions occurring in persons with cutaneous diseases have been called Kaposi's varicelliform eruption or pustulosis variolioformis acuta when there was no history of preceding vaccination or exposure to recently vaccinated persons.

Tedder in 1936 reviewed many of the cases reported as Kaposi's varicelliform eruption and pustulosis variolioformis acuta. His survey showed that the clinical features of these diseases and of eczema vaccinatum are identical. The failure to obtain a history of exposure to vaccine virus or the fact that vaccine virus could not be demonstrated in the lesions was in most cases the reason for their not being identified. It has been suggested that the eruptions known under these three names are identical and that the vaccine virus is the causative agent. However, since then in a number of cases diagnosed as Kaposi's varicelliform eruption or pustulosis variolioformis acuta the virus of herpes simplex has been recovered. A considerable number of cases have failed to yield either vaccinia or herpes virus, despite appropriate tests and this fact may be due to inoculation with yet other viruses.

It is now well known that the virus of vaccinia is definitely disseminated by the blood stream following vaccination. Paschen cited the work of numerous investigators who showed that the vaccine virus in all probability reaches every organ in the body. It is this hematogen-

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ous dissemination which is responsible for generalized vaccinia. Combes and Behrman state that the distinguishing feature between generalized vaccinia and eczema vaccinatum is that generalized vaccinia appears on a healthy skin, whereas eczema vaccinatum occurs only on a previously diseased skin. In addition generalized vaccinia is due to hematogenous dissemination of the virus from the individual's own vaccination site. While eczema vaccinatum may also occur in this manner, it usually follows accidental contact of the diseased skin with someone else's vaccination site, with a subsequent local and hematogenous spread of the virus.

In almost all of the cases of eczema vaccinatum that have been reported a pre-existing dermatitis was present and careful questioning elicited a history of exposure to some newly vaccinated person, a few days to several weeks before the outbreak of the vessicles.

The vessicles of eczema vaccinatum, appear on the previously diseased skin and exhibit the characteristic changes of typical vaccination



Generalized vaccinia or eczema vaccinatum on patient E. D. Note large confluent lesions on left elbow.

pustules. These pustules occasionally appear in crops from several days to a week after the initial outbreak. The patients are seriously ill with high fever and chills and clinically may resemble true variola. Typical pitting and scarring of the skin is frequently noted upon recovery. Death may ensue and a mortality of 12 to 30 per cent has been reported.

The diagnosis of accidental vaccination, generalized vaccinia or eczema vaccinatum depends upon clinical history and certain laboratory findings. There should be a history of vaccinal contamination within a period of two or three weeks before the onset of clinical symptoms. History of exposure of the patient to vaccine virus is extremely important and is often dif-



Patient E. D. showing typical vaccinal lesions on her atopic dermatitis. Note lesions are in various stages of eruption.

ficult to obtain. Because of the time element involved and because of the numerous, devious and unusual methods of exposure that may occur, repeated and careful questioning is required. In taking a history from parents and even from the patient it must be kept in mind that important sources of contact may have seemed trivial and irrelevant and hence are completely forgotten.

The Paul test is the most convenient and reliable diagnostic laboratory procedure available. Biopsy of an individual lesion is of value and may show Guarnieri bodies which are thought to be specific for the vaccinia virus.

REPORT OF CASES

E. D., an unvaccinated eighteen-year old white female, has suffered from an atopic dermatitis for the past three years and for several months has been under the care of one of the authors. On May 10, 1950, she reported to him for a regular office visit and complained of some lesions on her left elbow. She stated that on the day

before her elbow itched and while scratching it the lesions were noted. On examination approximately six or seven unbilicated vessicles filled with a turbid material were noted and a tentative diagnosis of virus pyoderma was made. The patient was again seen on May 12 and considerable spread to the hands, wrists, arms, and neck was noted. The diagnosis of smallpox, chickenpox, generalized vaccinia and Kaposi's varicelliform eruption were all considered, but careful questioning of the patient failed to reveal any significant history.

On May 14 the patient was visited in her home by the authors and was found to be acutely and severely ill with a temperature of 103°. She appeared quite toxic and complained of severe headache. A widespread and generalized eruption was present over the extremities, trunk, neck, and face, and even the eyelids were involved. Large confluent lesions were present on the arms and face. The eruption closely resembled that of true smallpox with the exception that the vessicles were in various stages of development.

Careful questioning of the patient and her family finally brought forth the statement that the patient's twenty-one year old brother had accepted employment at a nearby industry and that as an employment requirement he had recently been given "a shot" against smallpox. Upon questioning him, it was verified that he had been successfully vaccinated against smallpox on April 19 and prior to that time had never been vaccinated. On examination a successful primary vaccinal lesion now in the crusting stage was found to be present on his left arm.

The patient E. D., then recalled that on May 1, she laundered her brother's clothes and even recalled seeing the stains from his vaccination on his shirt sleeves. This was exactly 12 days after her brother's vaccination and within the 8 to 12 day period when his primary vaccinia was at its height. The appearance of her first lesions occurred exactly 9 days after this exposure to vaccinal virus.

This significant history, plus the typical clinical appearance of the lesions, now made positive a diagnosis of eczema vaccinatum or generalized vaccinia in an adult with an atopic dermatitis.

The patient had a stormy course being acutely ill for approximately nine days with recovery occurring about eighteen days after onset. Fortunately only slight pitting and scarring occurred on her face, but moderate to severe pitting and scarring is present on her extremities and trunk.

The patient's mother, Mrs. S. E., a forty-eight-year old unvaccinated person stated she had a "funny sore" starting in front of her left ear. Examination on May 17 revealed a typical accidental vaccination in about the fifth or sixth day of development. Mrs. S. E. had been caring for and dressing her daughter's numerous lesions and had thoroughly seeded herself with vaccinal virus. About five or six days after the appearance of her first lesion she developed two other lesions in her right external auditory canal and also developed a number of small vessicles adjacent to her original accidental vaccination site. All-in-all, she developed a total of seventeen vaccinal lesions. An uneventful recovery occurred with several typical vaccination scars resulting on her left cheek.

R. D., the twenty-three-year old husband of patient, E. D., also accidentally inoculated himself and developed a typical "immune take" on his left check below the eye. R. D. gave a history of having been vaccinated as a child and of being revaccinated while in the army in 1945, thus giving him a currently satisfactory immunity.

The only member of the household to escape accidental vaccination was the father, who gave a history of two successful vaccinations a number of years ago.



Accidental vaccination under left ear on Mrs. S. E., mother of patient E. D.

SUMMARY AND CONCLUSIONS

(1) Three cases of accidental vaccination are reported, one of which was a severe case of generalized vaccinia in an adult with an atopic dermatitis. These cases are presented because of their unusual interest and the difficulty that may be encountered in diagnosing such cases.

(2) A brief review of the literature on accidental vaccination, generalized vaccinia, eczema vaccinatum and Kaposi's varicelliform eruption is presented.

(3) Generalized vaccinia and eczema vaccinatum at times closely resemble variola, but lack the prodromal stage and the evolution of the lesions differ. Furthermore the report emphasizes the importance of obtaining a history of exposure to vaccinal virus in these conditions.

(4) Preventive procedures consist of the following:

(a) Properly instruct patients as to the care of vaccination sites and the possible danger of auto or hetero-inoculation.

(b) Keep recently vaccinated persons away from contact with non-immune persons, espe-

cially those suffering from a chronic dermatitis.

(c) Defer performing vaccination on individuals with cutaneous disorders.

(d) When vaccinating use the multiple puncture method with a small insertion using a total area not exceeding one-eighth inch in diameter and with 20 to 25 punctures.

(e) While shields, pads and dressings for vaccinations are contra-indicated because they favor softening and contamination of the vesicles, it is wise to pin or attach several layers of dry sterile gauze inside the sleeve so as to protect the vaccination site.

If these simple precautions are used, it will reduce to an even lower extent the present relatively rare incidence of complications following vaccination.

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Benefits, Also Complications, Result From New Hormones

Some of the complications that have arisen so far from the use of these hormones (Cortisone and ACTH) are hirsutism, diabetes in those susceptible to developing diabetes, excited agitated state in certain individuals and Cushings Syndrome.

The whole subject is most exciting and probably will play a big part, if not in the treatment, in enlightenment on the pathologic physiology of many diseases. The whole group of so-called collagen diseases seem to be benefited and also those diseases in which allergy in its broad sense seems to play a part.

So far these substances seem to be of probable value in: (1) hypopituitism, (2) Addison's disease, (3) allergy, (4) certain eye conditions, (5) nephrotic syndrome, and (6) rheumatic fever.

They seem to be of questionable value in: (1) rheumatoid arthritis, (2) lupus erythematosis disseminata, (3) periarteritis nodosa, (4) nephritis, (5) lymphomas, and (6) pneumonia.—Oliver Abel, Jr., M. D., St. Louis, Mo.; The Journal of the Missouri State Medical Association; Volume 47, Number 11, November, 1950.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Crista Galli—A term descriptive of the appearance of this process of the ethmoid bone which projects into the cranial cavity like a cock's comb. It is derived from the Latin words crista or crest and gallus, a cock or rooster.

Crazy—Literally means cracked or crack-brained and comes from the Middle English word crasen, meaning to crack or break. Also said to come from the French word ecraser, meaning to crush, crack or break.

Apothecary—This term comes from the Latin word apotheca, meaning a storehouse. During the middle ages, it came to mean a storehouse for drugs. The Latin word in turn comes from the Greek apotheke, which meant any kind of storehouse, granary or keeping place. It is derived from the Greek apo, or from and theke, a box or chest.

Dyspareunia—This term for painful sexual intercourse literally means difficulty in lying beside or going to bed with. It comes from the Greek dys or difficult and pareunos or lying beside.

Diaper—This word is derived from the old French term diaspre, which was applied to a type of figured linen cloth of which table napkins were frequently made. Hence the term was also applied to a napkin for an infant. The term diaspre is said to be a corruption of the name d'Ypres because this type of cloth was manufactured in Ypres, France.

Kaolin—This clay-like substance which is a silicate of aluminum was introduced into France in the early part of the 18th Century by Father d'Entrecolles a missionary in China. The French word kaolin is a corruption of the Chinese words kau-ling, meaning high ridge and the substance was so called from the place where it was first found.

Comedo—When a blackhead or comedo is expressed it has a worm like appearance and it was formerly believed that there was an actual worm present which ate into the flesh. Hence the name comedo was given to these lesions, for the word in Latin literally means a glutton and comes from comedere, meaning to eat up.

Microbe—This term was suggested by Dr. Sedillot, a famous French physician in a paper he read in 1878 before the Academy on the subject of Pasteur's influence on medicine and surgery. Pasteur promptly adopted the word and soon the whole world was familiar with it. The word was coined from the Greek words mikros or small and bios or life.

—Harry Wain, M. D., Mansfield, Ohio.

The Prevention and Treatment of Deafness in Childhood

HARRY C. ROSENBERGER, M. D.

IN this presentation deafness will be understood to mean either total or partial loss of hearing although otologic literature prefers to designate the partially deafened as hard of hearing. It is not only fitting but important that an annual convention of doctors of medicine, specialist and family doctor alike, should give some consideration to this problem. Unfortunately for the deafened there is no white cane or tell-tale crutch to excite the sympathies. On the contrary deafness is the only disability that actually provokes hostility toward the victim for the lack of hearing unfortunately is often misinterpreted as stupidity or rudeness.

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EXTENT OF DEAFNESS PROBLEM

If we physicians are interested in securing the greatest therapeutic return for the least medical effort then it is in childhood deafness that we must emphasize and vigorously utilize the concepts of deafness prevention and treatment. Every physician knows that of 100 hard of hearing adults possibly 50 suffer the affliction needlessly. These 50 are the tragic symbols of medical neglect or, even worse, of medical incompetence during the patient's childhood. Every physician knows or should know that three or four million school children in the United States have hearing defects of varying degree. Of these three or four million school children fully 70 per cent have a remediable hearing defect. Since every practicing physician has a Hippocratic responsibility for the otologic welfare of these thousands of children it is timely to enquire into the ways in which we may discharge our obligations toward this group.

HEREDITARY AND CONGENITAL FACTORS

In our busy professional lives we are apt to forget that the unborn child may be crippled acoustically by the inherited genes of familial deafness. Otosclerosis is a case in point. We doctors must be increasingly conscious of the role of eugenics in the ills of our patients. In the contemplation of matrimony the compatibility of chromosomes would seem to be fully as important as the compatibility of temperaments. Thus we see that heredity may be a factor to consider in the prevention of deafness.

As regards congenital deafness it is possible for the unborn child to suffer acoustic damage from certain drugs ingested by the mother. As is well known the administration of large doses of quinine, salicylates and other medicaments to susceptible individuals may jeopardize the auditory function of the fetus.

Another example of congenital deafness is that induced by the childhood malady of rubella or German measles afflicting the pregnant woman in the first trimester of gestation. In this early state of fetal development the neural epithelium seems unusually susceptible to the action of toxins. Therefore, if we are to do anything constructive about the correction of these hereditary and congenital hazards to the hearing function, the first step is the recognition that these hazards exist.

THE ROLE OF THE COMMON COLD

Early in our consideration of the prevention of deafness we must come to grips with that evil ogre, the common cold. In spite of the deluge of advertising of the past winter relative to the many cold cures, you and I know that this largely is wishful thinking, to use a euphemism, and that the common cold and its dire effects are still with us. The common cold is the precursor of congestion and blockage of the nasal passageways and the Eustachian tubes. This, of course, interferes with the proper drainage and ventilation of the paranasal sinuses and the middle ear spaces. In consequence there may follow suppuration of these spaces. This eventuality may be hastened by improper and imprudent blowing of the nose.

In one respect at least it would be fortunate if suppurative otitis media were the only consequence of these congestive states induced by the common cold for then the unhappy victims would seek medical relief because of pain. In this way guidance could be offered to the sufferers and deafness prevention instituted. On the contrary, more often the congestive state stops short of suppuration and pain and produces merely an edema and cellular reaction

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within the mucous membrane. In the middle ear spaces there often is added a transudate which offers still more hindrance to the proper functioning of the part. If these conditions persist the mucous membrane undergoes myxomatous change, fibrous tissue is formed and ossicular movement is interfered with.

INSIDIOUS NATURE OF CHILDHOOD DEAFNESS

The particular noxiousness of this process lies in the partial loss of hearing that goes unrecognized and untreated together with the lack of discomfort which lulls the victim into neglect of indicated therapy and promotes a false sense of well-being. To be of aid to this group of hearing defectives who more often than not are unaware personally of their handicap we must practice what might be termed medical sleuthing. We must keep in mind that these patients exist in great numbers and we must search them out. We must remember that it is in childhood that these hearing losses are frequently reversible but if untreated they constitute the initial phase of a greater and often irreversible defect in later life.

DEAFNESS AND DISEASED ADENOIDS

Diminished hearing in childhood due to congestion of the Eustachian tube can result from other conditions besides the common cold. I refer particularly to tubal catarrh incident to obstructing or diseased adenoids. It is both spectacular and satisfying to observe the spontaneous improvement in a child's hearing following a therapeutically indicated and well performed adenoidectomy. Crowe of Johns Hopkins has rendered children and otology a service by calling attention to the relationship of diseased, hypertrophied adenoids to hearing loss in childhood. It is regrettable that the use of radium to alleviate this condition has been so overemphasized. Here again the prevention of hearing loss must first begin with its being looked for and then will naturally follow the appropriate remedy.

AUDITORY DAMAGE FROM CONTAGIOUS DISEASES

In considering methods of deafness prevention in childhood we must recall that auditory damage may follow certain of the contagious diseases common in childhood. Mumps and meningitis are two such diseases. In epidemic parotitis one or both ears may be involved and if unilateral the disability may escape detection unless looked for. The early use of convalescent serum may be beneficial. Meningitis, whether epidemic or pyogenic in origin, constitutes a serious hazard to the hearing. The meningococcic type carries the greater risk to the hearing but use of the antibiotics has been efficacious. Ten years ago scarlet fever was a common cause of impaired hearing but today, thanks to chemotherapy and the antibiotics, it no longer is the dreaded destroyer of auditory function. I am sure that many of us can recall the marked invasive and destructive qualities of the "scarlet ear."

DEAFNESS PREVENTION BY AUDITORY SCREENING

Certainly the greatest single forward step in deafness prevention in childhood has been the introduction and development of screening tests for auditory dysfunction in school children which now is a duty of all metropolitan school systems, while in the rural areas it is carried on under supervision of the State Department of Health. This health procedure is comparable to the mass chest survey conducted by the Red Cross in the fight to stamp out tuberculosis. By the routine testing of hearing of grade school children there is brought to light not only the neglected discharging ear with impaired hearing but also, and even more important, the thousands of ears which are the seat of a congestive process causing only minor hearing loss. Here is the one difficulty most universal and most prolific of ill consequence to the patient but which lends itself fortunately to the most brilliant therapeutic results. It truly is a harvest ripe unto the reaping.

In harmony with the auditory screening program of the modern school system it would be a salutary thing if every practicing physician who makes a physical examination would include an evaluation of his patient's hearing function. This applies especially to children and young adults. It should be more thorough than merely to demonstrate adequate binaural hearing for ordinary conversation but need not require elaborate equipment or the expenditure of much time. Indeed, if nothing more were done than to note the child's hearing response to an ordinary pocket watch the effort would be laudable, the technic excusable and the results beneficial to all concerned. A child with a hearing function depressed more than slightly could then be investigated more thoroughly.

PITFALLS IN ANTIBIOTIC AND CHEMOTHERAPY

Passing on now to a consideration of the treatment of deafness in childhood it must be pointed out that the following remarks are largely generalizations rather than specific recommendations. The ear condition that most frequently brings the little patient to the family doctor is the aching ear of otitis media associated with the common cold or other upper respiratory infection. Whether good or bad it nevertheless is a fact that the routine prescribing of chemotherapy or antibiotics for this complication has become almost a standard practice among many medical practitioners. That good has been accomplished is indicated by the marked lessening of chronic discharging ears and surgical mastoiditis since these newer drugs have been commonly used.

That harm has possibly resulted in some instances by the masking effect of these drugs on important symptoms cannot be denied. Moreover, warnings have been sounded by informed workers that the indiscriminate and faulty use of chemotherapy and antibiotics may provoke a condition of drug fastness in the patient or organism which later may engender serious consequences to the patient when his need for these drugs may be greater. If it is decided to use these newer drugs then they should be used with the necessary precautions, in adequate dosage and with alertness for possible masking.

Another condition that far too often insidiously and progressively pilfers the hearing reserve of the unsuspecting juvenile patient is the so-called catarrhal otitis that often is concomitant with or follows the severe and prolonged head cold. This difficulty the child will seldom identify or complain of and it must be suspected and searched for by the interested and vigilant practitioner. Its treatment is variable but often includes some form of tubal inflation. Associated sinusitis and diseased tonsils and adenoids must receive appropriate attention together with attempts to control any allergy that may be present.

THE CHRONIC DISCHARGING EAR

It is wise to say something about the treatment of the chronic discharging ear which happily is seen less and less among the school population. For medical men who view with complacency the chronic discharging ear of childhood a word of censure must be spoken. The chronic discharging ear is always important for it jeopardizes the hearing if not life itself. With persistent and adequate treatment together with necessary surgery when indicated it is surprising and gratifying how often the chronic discharging ear becomes dry. It is well to remember the rule of thumb that designates as potentially serious the ear that discharges longer than four weeks no matter how mild the associated symptoms.

NECESSITY OF DOING GOOD ADENOID SURGERY

No discussion of the problem of deafness in childhood would be complete without reference to the spectacular hearing improvement which occasionally follows the surgical removal of diseased adenoids. There can be no denial of the fact that hearing can be improved by the removal of diseased or obstructing adenoids. Unhappily this truth is sometimes debased by using it as justification for the performance of unnecessary and unjustified surgery. To be moral our surgery should be indicated and it should also be well done. As an examiner for the Army in World War II, in my association with a training program for residents in otolaryngology and in my private practice, I have seen the results of both good and bad tonsil and adenoid surgery. I might aphoristically summarize my impression of this surgery by stating that it is no better than the scruples and surgical training of the surgeon performing it. It therefore follows that the frequency and degree of hearing improvement following adenoid surgery will be directly proportional to the indications for, and to the thoroughness and skillful performance of, the operation.

USE AND ABUSE OF RADIUM

Utilizing the depressing effect of irradiation on cellular mitosis the present enthusiasm, one might almost say frenzy, for the use of radium applicators in the nasopharynx in cases of childhood deafness has gotten somewhat out of bounds. At the last meeting of the American Academy of Ophthalmology and Otolaryngology considerable information was presented by various specialists including a physicist and a radiologist calling attention to the basic dangers inherent in such therapy. It was strongly recommended that the radium applicators for the nasopharynx be used with much more caution than heretofore in the interest of both the patient and the doctor. This advice would seem to be well considered and timely and will in no way deprive the occasional needful patient of this form of therapy. Surgery, with emphasis on well done surgery, should still be the first choice in most cases for eradicating the diseased or hypertrophied adenoid. Irradiation should be reserved for the exceptional case of adenoid mass or lymphoid follicles inaccessible to surgical attack.

NECESSITY FOR LIP READING AND SPEECH TRAINING

Although lip reading and speech training are consigned to the last paragraph in this presentation this fact in no way indicates their importance in the scheme of the prevention and treatment of deafness in childhood. It would exercise a sobering influence on all of us were we to visit the Ohio State School for the Deaf at Columbus. There we would see some 300 resident children whose hearing is so inferior as to require special training in lip reading. Also, by reason of their inadequate hearing, the speech of these children is likewise so faulty that speech training is mandatory.

REHABILITATION CLINICS FOR HEARING DEFECTIVES

War, along with all its attendant misery and tragedy, also produces or hastens the development of ideas and technics that aid humanity. With the impetus of the last World War there were developed in the United States several military Rehabilitation Centers for the acoustically handicapped. These Centers are for the 2½ million veterans who suffered acoustic disability and they are excellent models of efficiency.

However, no such superlative assistance exists for the aid and comfort of the 13 million acoustically handicapped adult and juvenile civilians. Nevertheless, a beginning has been made, paced by such institutions as the Lexington School for the Deaf in New York and the more recent John Tracy Clinic in Los Angeles.

Here in Ohio in addition to the Ohio State School for the Deaf, we have in Cleveland the Alexander Graham Bell School for the hard of hearing and the Cleveland Hearing and Speech Center affiliated with Western Reserve University. Ohio State University has a similar affiliate while there are some fifteen smaller hearing centers throughout the State. The existence of these various schools and centers bespeaks the growing public and private interest in the problem of the acoustically handicapped child. In this connection it is of interest to know that last year in Ohio some 1300 acoustically handicapped children were enrolled in public hard-of-hearing schools and classes and that this service in the school year 1947-48 cost the taxpayer $266,000.

CONCLUSION

In conclusion it is evident that much has been done and much more remains to be done in the drive for the prevention and treatment of deafness in childhood. To be successfully carried out this problem needs not only the best efforts of otologists but especially the intelligent and sympathetic cooperation of all pediatricians and doctors in general medical practice.

SUMMARY

1. There can be no adequate prevention or treatment of deafness in childhood until it is recognized that actual or potential deafness exists.

2. Practitioners of medicine must be willing to acquire and to use the simple testing technic that will indicate the presence of diminished hearing.

3. Patients so diagnosed must receive the necessary treatment either from the family doctor or by referral to an interested otologist.

4. It must be common professional knowledge that treatment is only one factor in the control of the deafness problem, the others being deafness prevention, lip reading and the improvement of faulty speech in the acoustically handicapped.

It is estimated that 40,000 people die in the United States each year from carcinoma of the stomach. This is an appalling number, to say the least. The reported 5-year survival rates . . ., indicate that the surgical treatment of carcinoma of the stomach leaves much to be desired and presents a vital challenge to the medical profession.—Sawyer & Marvin, Denver; J. of the Kansas Med. Soc., 51:457, 1950.

KEEPING UP WITH MEDICINE

• HYPERVENTILATION produces a fairly definite pattern of symptoms—headache, lightheadedness, dizziness, constriction around the chest, dyspnea, palpitation, numbness and tingling of the extremities.

* * *

• THE eating of liver for the relief of weakness was recorded in the history of many ancient peoples.

* * *

• WHENEVER you see a patient with a dermatitis and perhaps spikes of fever and abdominal pain, you should think of drug allergy and stop the medication at once.

* * *

• LAST year for the first time, there were less than 1000 deaths from whooping cough in this country.

* * *

• PHOTOSENSITIVITY on an allergic basis can be differentiated from food and pollen allergy in most cases of solar dermatitis.

* * *

• SOME of the side effects of aureomycin are interesting: mucuous membrane changes have been reported in the form of perianal irritation, gross angular stomatitis, cheilosis, vesiculopapular eruptions on the buccal mucosa, glossitis (occasionally the black hairy tongue), vaginitis and vulvitis.

* * *

• THE association of enuresis with abnormally heavy sleep has received scant attention.

* * *

• IN congestive heart failure it is desirable to restrict the sodium intake as a maintenance program. The desired limitation of sodium may be attained if salt is not used in the cooking, if salt is not added at the table, and if salted crackers, meats, fish, potato chips, cheese, broths, bouillon, pickles, relishes, gravies and salted butter are omitted from the diet.

* * *

• THE family is the basic economic, reproductive, and educational unit in every known society.

* * *

• SOME of our students of cancer are now prepared to transfer their experience with mice to human beings and to warn all women with family histories of cancer NOT to nurse their babies. In this connection it would seem wise if they were to discover what percentage of women with breast cancer ever nursed their mothers.

* * *

• THE advantage of mask therapy is its ability to provide high concentration of oxygen economically.—J. F.

Cancer of the Tongue*

ARTHUR G. JAMES, M. D.

CANCER of the tongue is an important disease because it causes more deaths than any other head and neck cancer. Next to cancer of the lip, it is the most frequently occurring one in or about the oral cavity. The results have improved in recent years due to refinements in both radiation and surgical technique, and if early suspicions are confirmed by biopsy and appropriate therapy is applied, the chances of curing the patient are good.

Cancer of the tongue occurs in both sexes, but is about six or seven times more common in the male. It occurs most often in the fifth to seventh decades, although it has been noted to occur in the teens and in the ninth decade. It may occur on any part of the tongue but is most frequent on the lateral margins and especially in the middle third.[1] The second most common area is the base. It is difficult to properly evaluate the contribution of chronic irritation to the formation of lingual cancer. These lesions have been seen to develop in areas that have been continuously irritated by an irregular or jagged tooth. About one-third of the patients with cancer of the tongue also have syphilis.

Lingual cancer tends to be almost symptomless in its early stages. The usual story is that the patient himself discovers either the primary lesion or a metastatic node and the only complaint is of its physical presence. Occasionally pain is the first symptom, but is usually never as painful as the benign ulcerated lesions of the tongue such as herpes or traumatic ulcers. If the lesion occurs in the base of the tongue, hoarseness, dysphasia or dyspnea may occur, depending upon the size of the tumor. Necrosis and hemorrhage are usually late symptoms.

DIAGNOSIS

Cancer at the base of the tongue may be overlooked because the physician is sometimes prone to ascribe vague soreness of the throat to an enlarged pair of tonsils. A diagnosis of cancer of the tongue should always be verified by the pathologist. A tentative diagnosis is not difficult in the usual case. Cancer should always be suspected in chronic ulcers or indurated areas in any part of the tongue. A specimen for biopsy should be taken early, preferably at the first visit of the patient. This can very easily be performed with local anesthesia and a biopsy forcep. If the lesion is located in the base it may not be obvious on direct inspection of the oral cavity with flashlight and tongue blade. A laryngeal mirror may be necessary to view the base as far as the valleculae. A biopsy specimen of the base can easily be taken with a curved forcep. One should not hesitate to perform a biopsy just because a patient is luetic. **There is never any justification in delaying biopsy in order to rule out a gumma by therapeutic trial.** The occasional lesion that will turn out to be a gumma will heal just as well whether or not a specimen for biopsy was taken. The idea that syphilis may simulate any disease was so well taught to the past generation of physicians that many times a tumor of the tongue is called a gumma just because the Wassermann reaction happens to be positive. A biopsy specimen from a fungating cancer of the tongue is usually best taken by a biting forcep.

TREATMENT

The treatment of cancer of the tongue depends on the type of cancer to be treated, on the location of the lesion, and whether or not metastatic nodes are present in the neck. Adenocarcinomas, sarcomas, and other radioresistant lesions should be treated by surgical eradication whenever possible. In the main, cancer of the tongue is epidermoid in type. This is usually a radiosensitive tumor. The treatment of this type of lesion when located in the base is best by high voltage external radiation, plus interstitial radium. In this manner the lesion can be controlled in a very high percentage of times.

In general, three external ports are used, one on either side of the neck and one in the suprahyoid region. It is very important that these

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ports be centered by actually palpating the base of the lesion and determining as accurately as possible where the center of that lesion would be projected onto the skin surface. These centers can be permanently located by tatooing that area with India ink. This insures against the mark being washed away and using a slightly different center for each treatment. These ports should be just large enough to cover the lesion, plus a little of the surrounding normal tissue. Circular ports are preferred to square ones because by actual figuring about 20 per cent less normal tissue is irradiated. For the usual case these ports are from five to seven centimeters in diameter.

The amount of radiation given will vary with the size of the ports and with the amount of interstitial radium used. In general, the dosage of external radiation is brought up to skin tolerance. We prefer interstitial radium in the form of radon seeds rather than the element needles. These have several advantages over the element. They may be implanted through the skin of the neck in surgically cleaned fields instead of being inserted through the mouth and directly through the mucosa of the tongue, which is usually at least somewhat ulcerated and superficially infected. The radon seeds are more economical than the element. The process of inserting radon seeds is less cumbersome than using the needles because it is not necessary to remove the seeds. They may be inserted and in a few minutes the patient may be on his way.

When the lesion is located elsewhere on the tongue, the treatment may be x-ray and radium or by surgical excision. The decision is usually made on the basis of whether a peroral cone can be used to cover the lesion. The cone treatment yields as many cures as partial glossectomy, yet functionally the results are better. A field just large enough to cover the lesion is used and the amount of radiation given depends upon the size of the port and whether low or high voltage radiation is used. If the patient develops positive neck nodes at a later date after the primary has been controlled, **the best possible treatment is by radical neck dissection.**

SURGICAL TREATMENT

Many operations have been graced by the term "radical neck dissection." What we mean by the term is an operation which exposes the entire side of the neck and removes the sternocleidomastoid muscle, internal jugular vein, and all the lymphatic-bearing tissue between the clavicle below, mandible above, and between the skin and the deep muscles of the neck. If the primary happens to be a carcinoma of the base of the tongue and at the same time a single node metastasis is present in the neck and especially if that node be located in the upper jugular chain, then we prefer to treat that node by radiation at the same time that the base is irradiated. The reason for this is that it makes it possible to treat both lesions at the same time. Otherwise, we would have to wait until the primary lesion were controlled before the neck dissection could be carried out or vice versa.

If massive neck metastases are present at the same time that the primary lesion is being considered for treatment, then we feel that the best treatment is by combined neck dissection and resection of the primary tumor at the same time. In this operation a portion of the mandible is removed. It is a good cancer operation because it removes the primary tumor, the metastatic areas and all the intervening lymphatic tissues as one specimen. This operation is very useful in cases where the primary tumor has been inadequately radiated and there has been persistence or recurrence of disease, and especially in cases where this primary tumor has eroded into the floor of the mouth or into the mandible. Many cases that are absolutely hopeless by any other form of treatment may be salvaged by this radical surgical eradication. The deformity following this type of procedure is not great. The patients are able to eat and to talk almost as well as before surgery.

SUMMARY

1. Cancer of the tongue is second only to lip cancer in its incidence of occurrence in malignancies of the head and neck.

2. It is easily possible to overlook a carcinoma of the base of the tongue with tongue blade and light examination only.

3. A laryngeal mirror examination and digital palpation should be part of every examination of the tongue when a tumor is suspected.

4. There is no contraindication in performing a biopsy of the tongue as an office procedure. This should be done—as a rule—on the first examination of the patient.

5. The treatment of carcinoma of base of the tongue is usually by radiation. Elsewhere on the tongue, carcinoma may be treated either by cone radiation or by partial glossectomy.

6. Cervical node metastases should be treated by radical neck dissection.

7. If a lesion of the base of tongue is bulky and comes near the bone, and in addition there are metastatic nodes in the neck, then the only possible treatment that stands a chance of salvage is a radical procedure that combines radical neck dissection with resection of the mandible and involved tongue.

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Unilateral Hodgkin's Granuloma, Cause of a Sudden And Unexpected Death

WILLIAM KULKA, M. D.*

HODGKIN'S disease[1, 2, 3] or Lymphogranulomatosis[3, 5, 6] is characterized by its specific effects on lymphoid and reticuloendothelial tissue wherever they are found in the body. The French call it a "Maladie de frontiere," i. e., a disease which presents symptoms of inflammation[2, 6] as well as neoplastoid qualities.[1, 2] The cause of this disease is still unknown in spite of the numerous postulations and conjectures involving various etiological agents.[1, 2, 3, 5]

This borderline position has attracted the interests of pathologists and clinicians increasingly since the publications of C. Sternberg[7] and D. Reed.[8] Studies and interest have been stimulated continuously by the intensive development of virus and tumor research. This is demonstrated by the exhaustive review of Horter, Rolnick, et al., of the Hodgkin's Research Foundation. This work published in 1948 listed 572 papers on the subject.

Important factors that hinder the inquiry are: first, the low incidence of the disease (estimated as 0.5 to 2.4 per 100,000)[1, 2] and secondly, the lack of a reliable specific clinical test other than biopsy. The value of the Gordon test[1, p.61] on animals (producing encephalitis in rabbits) is controversial and considered rather impractical due to the necessary delay in the production of positive results. A third factor retarding the progress of the study of this disease lies in the limited number of published reports of autopsies of uncomplicated cases. Jackson and Parker,[1, pps. 5 & 10] cited only 63 cases in 18,668 autopsies at the Boston City Hospital performed during the period of 1897- 1946. Since the introduction of effective x-ray therapy the reports of postmortem examinations of untreated cases have become exceedingly rare. Consideration of these facts prompted me to present the following case.

CASE HISTORY

A white female, 30 years of age, died suddenly in the backyard of her home. As reported by her mother, the girl was affected upon detection of fumes leaking from a refrigerator in the basement. The mother rushed the daughter up a short flight of stairs intending to escort her to a neighbor's home but the daughter collapsed suddenly and attempts to revive her were futile. These circumstances made the case subject for investigation by the coroner's office.

Data furnished by police reports, members of the family and the physician who treated the deceased several times before her death yielded additional, although incomplete, information. Prior to the age of 10 years she had suffered from several attacks of tonsilitis and chorea. Following tonsillectomy, the chorea subsided. There was no history of injuries or illness, except measles. There was no recollection of swollen lymph nodes in the cervical or axillary regions. Beyond the above mentioned conditions in childhood, she was never under a doctor's care until three months prior to her death. She was described by her family as having been robust and active as a Girl Scout leader. During World War II she worked for a while as a drill press operator. A routine x-ray inspection in 1942 revealed no abnormality in the chest. There was no history of tuberculosis, fainting spells, dizziness or any symptomatic pruritus.

Approximately three months before death she developed a progressive cough and, later, attacks of dyspnea. These symptoms improved when the patient assumed a sitting position and increased in severity following physical exertion. The physician consulted made a tentative diagnosis of asthma. The cough was relieved by medication. Unfortunately x-ray inspection was not made at this time.

ABSTRACT OF AUTOPSY FINDINGS

The body was that of a well nourished white adult female, 62 inches tall, weighing 158 pounds. The cervical and axillary lymph nodes were not markedly enlarged. A slight pitting edema was demonstrated in the legs.

On opening the body, the subcutaneous fat in the abdominal wall measured 5 - 6 centimeters.

From the Coroner's Office, Cuyahoga County, Ohio.

* Submitted to The Journal by the author May 10, 1950, this article is published posthumously, Dr. Kulka having died on July 19, 1950.

The Author

● **Dr. Kulka, Cleveland, Ohio, who died July 19, 1950, was a graduate of the University of Vienna, Austria, 1905; a native of Austria, he came to the United States following the Nazi invasion of that country in 1939. At the time of his death Dr. Kulka held memberships in The American Society of Clinical Pathologists, the Ohio State Society of Pathologists, the Cleveland Society of Pathologists, the Academy of Medicine, Cleveland, the Ohio State Medical Association, and the American Medical Association. He was formerly, pathologist, Our Saviour's Hospital, Jacksonville, Ill.; later, in charge of laboratories of Millard Fillmore Hospital, Buffalo; from 1944 until deceased, was pathologist on coroner's staff, Cleveland, Ohio, where he became head of the laboratory of pathology and forensic medicine.**

There was no marked abnormality in the skull or brain.

Chest:—The mediastinum was displaced to the right. The left pleural cavity was filled with 5500 cubic centimeters of a yellow tinged, cloudy, plasma-like fluid which clotted when removed from the body. The entire left parietal pleura of the thoracic wall, the diaphragm, and part of the left side of the pericardial sac was lined by a yellowish pink to grayish white layer of nodulated, granulated tissue. The nodes were 5-10 millimeters thick. The visceral pleura of the left lung was likewise coated with grayish white tubercle-like nodes. The left lung weighed 180 grams and was grayish red, shrunken and atelectatic.

There was no fluid in the right pleural sac. The right visceral and parietal pleura appeared smooth and glossy. The right lung weighed 380 grams and was grayish red and aerated.

The thoracic duct was hidden under the layer of granulated tissue but showed no marked abnormality grossly.

In the pericardial sac there was about 50 cubic centimeters of a clear yellowish fluid. The heart was displaced somewhat to the right, was small (180 grams) and contracted, but showed no abnormality on cross section.

Lymph Nodes: Chains of lymph nodes along the left side of the trachea and along the onsets of left carotid and subclavian arteries were grayish red and enlarged to the size of a cherry. Some were matted together.

The lymph nodes at the tracheal bifurcation and at the hilus were grayish white. They were markedly enlarged to the size of a walnut and moderately hard. Some of them were matted together. One was closely attached to the left main bronchus but did not erode its wall.

On cross section these enlarged lymph nodes were yellowish white to grayish white. Where matted together, the separating lines between them were distinct.

Abdomen: The diaphragm was positioned at the third rib on the right side but descended to 6 centimeters below the costal arch on the left, displacing the fundus of the stomach to the right. The spleen was moderately enlarged weighing 290 grams and displaced downwards. The grayish white follicles were enlarged, slightly bulging, and irregular in size.

There was no gross abnormality in the gastrointestinal tract.

The liver was moderately enlarged (1700 grams) and showed several hard white nodes of rice kernel size in the capsule.

The kidneys, the urinary bladder, the menstruating uterus, the ovaries and tubes showed no abnormality.

The mesenteric lymph nodes showed no gross abnormality but the retroperitoneal lymph nodes along both sides of the abdominal aorta from the hiatus of the diaphragm to the bifurcation of the aorta were enlarged in the same manner as those in the thorax. Some of them were matted together. They were yellowish pink and softened or, when matted together, grayish white and fibrotic on cross section.

The inguinal lymph nodes in the left inguinal triangle were moderately enlarged.

The endocrine glands and the persistent thymus showed no abnormality grossly or on cross section.

MICROSCOPIC EXAMINATION

Left Lung: (Figure 1) The alveoli were collapsed, the alveolar capillaries and the pulmonary veins widened and filled with blood. The visceral pleura was fibrotically thickened and enclosed multiple nodes consisting of masses of epitheloid cells surrounded by lymphoid cells. There were some large cells with a lobulated nucleus of the Sternberg-Reed character, several

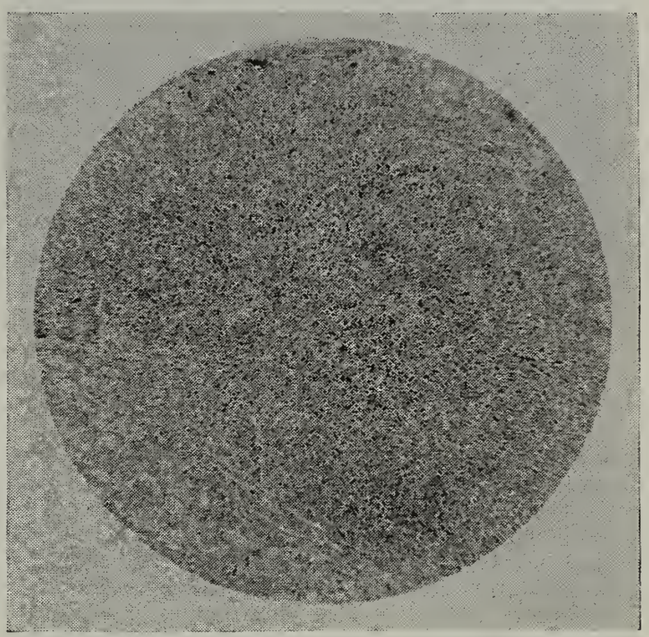


Fig. 1—Granuloma node in pleura of left lung dividing collapsed pulmonary alveoli (lower part of photo). (1:100)

polynuclear giant cells and quite a number of eosinophile cells present. The nodes which were surrounded by a thin layer did not invade the pulmonary parenchyma. Only occasionally a group of lymphoid cells could be seen within the connective tissue surrounding a small bronchus.

Right Lung: (Figure 2) The right lung showed signs of acute pulmonary edema but no trace of granuloma-like material.

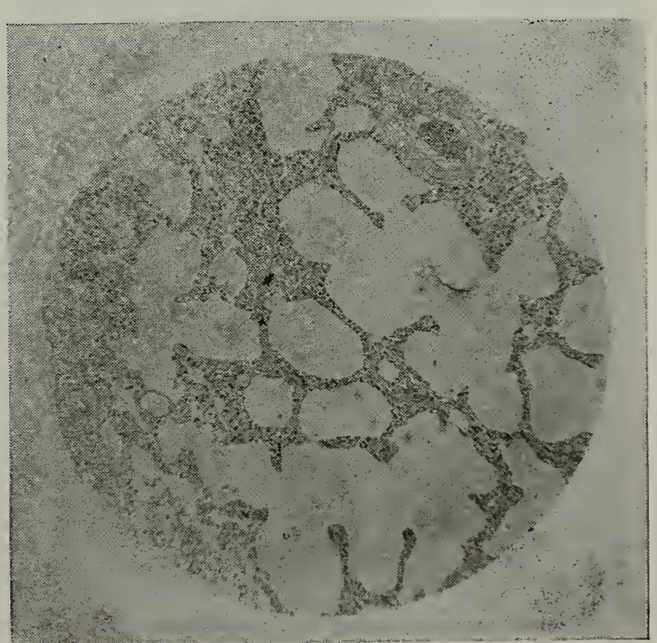


Fig. 2—Right lung. (1:140)

Tumor Mass Lining Wall of Left Thorax: (Figure 3) The tumor mass lining the wall of the left thorax consisted of a more or less node-like arrangement of layers of epitheloid cells, reticuloendothelial cells, some plasma cells,

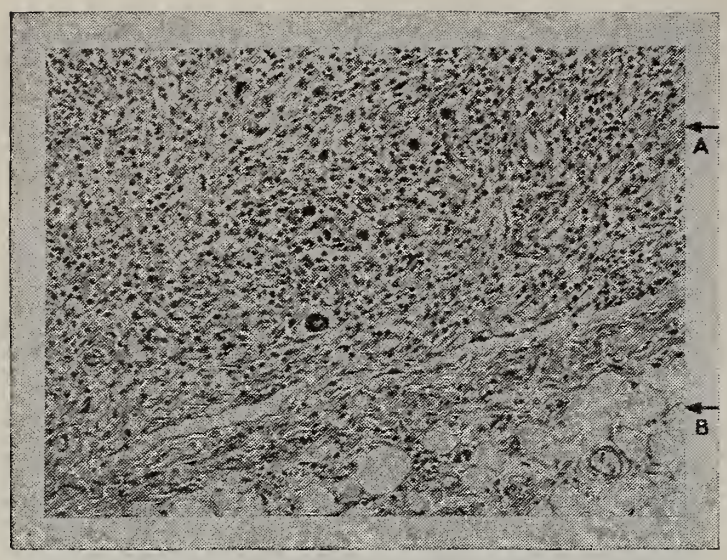


Fig. 3—Granuloma node in pleura costalis.
(A) Granuloma tissue.
(B) Connective tissue between pleura costalis and periosteum of ribs. (1:125)

enlarged cells with lobulated nuclei (Sternberg-Reed), an increased number of polynuclear giant cells and many eosinophiles. The stroma, when visible was made up of a network of thin fibers which occasionally were replaced by layers of dense fibrous tissue. Blood vessels were conspicuously absent. The findings presented the typical pictures that are considered as characteristic for Hodgkin's granuloma.

Nowhere did the granuloma tissue invade the periosteum and the bony structure of the underlying ribs or the intercostal muscles and their fascia.

Tumor Mass Lining Left Diaphragm: (Figure 4) The tumor lining the left diaphragm was of the same structure as that lining the wall of left thorax. The fascia of the musculature of the diaphragm likewise was not affected.



Fig. 4—Granuloma lining left diaphragm. (Fascia and musculature at lower edge of picture.) (1:100)

Mediastinal, Left Paratracheal and Retroperitoneal Lymph Nodes: (Figures 5 and 6) The normal picture was to a great extent or entirely replaced by masses of granuloma-like tissue rich in eosinophile cells, again characteristic of Hodgkin's granuloma. Nowhere was the fibrous

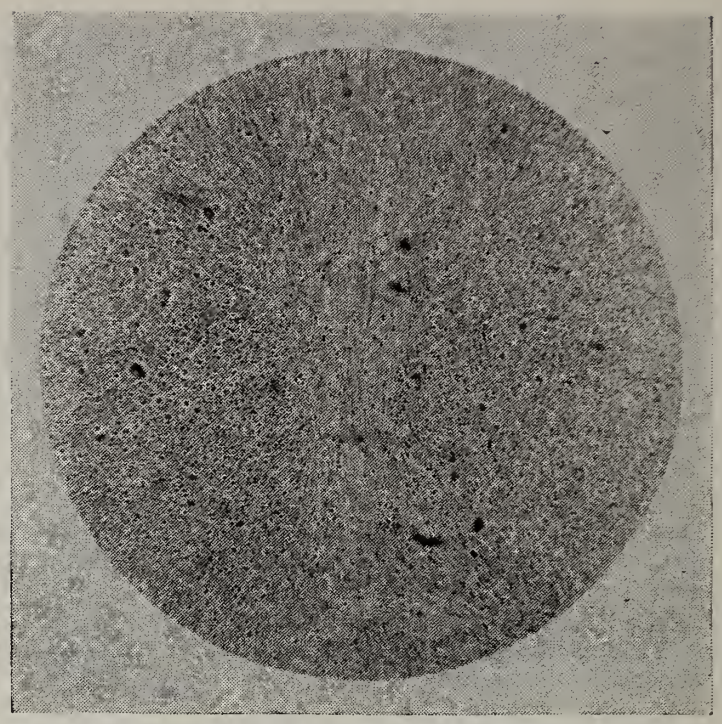


Fig. 5—Granuloma and fibrosis in lymph node. (1:140)

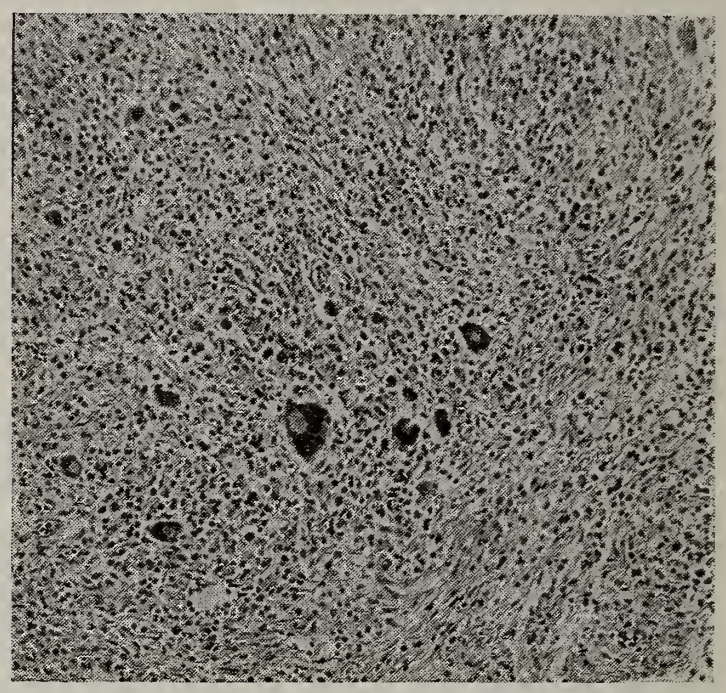


Fig. 6—Hodgkin's granuloma in pleural node. (1:400)

capsule invaded or broken through, not even where the lymph nodes were matted together. In large lymph nodes the described mixture of cells was less impressive and replaced by fibrous stroma rich in collagen,

Spleen: A number of lymphoid follicles were replaced by nodes consisting of granuloma tissue as previously described.

Ribs: Cross section through the sixth rib of the right side showed a picture of callus formation. Cross sections of the left ribs were entirely normal in appearance.

SPECIAL STAINS

Special stains of lungs, lymph nodes, granuloma tissue and spleen failed to reveal the presence of any organism. Acid-fast granules, resembling minute organisms, seen in the slides stained according to Ziehl-Neelsen technique, later could be identified as eosinophilic extracellular granules.

Slides of blood and bone marrow revealed no marked abnormality.

Fluid from Left Pleural Cavity: The fluid from the left pleural cavity was of plasma-like ap-

pearance rich in fibrinogen and other serum proteins. The sediment obtained by centrifugation was stained according to Gram's, and Ziehl-Neelsen methods and with hematoxylin-eosin. No organism of any kind was visible. However, there were some shadows of red cells, many mononuclear cells, a number of larger cells resembling the Sternberg-Reed type. Not infrequently polynucleated giant cells were seen.

DIAGNOSIS

All these descriptions led to the following diagnosis: Rapidly growing Hodgkin's granuloma of the entire left pleura involving mediastinal and retroperitoneal lymph nodes and the spleen caused an enormous left pleural effusion with collapse of the lung and marked displacement of the heart and mediastinum to the right.

DISCUSSION

Noteworthy features in this case are: (1) the rapid development of the disease uncomplicated by tuberculosis or other conditions with fatal termination, (2) the slight degree of fibrosis, (3) the absence of cachexia, (4) the predilection of the pathology to one side of the body.

Hodgkin's disease is generally characterized by a progressive enlargement of the lymph nodes in chains or groups, the enlargement extending over a period of months or years. The differential diagnosis from tuberculosis which frequently follows in the wake of Hodgkin's disease and (terminally) from sarcomatous changes in the absence of other reliable tests must be based on biopsies and blood findings.

The age of 30 coincides with the computation of Jackson and Parker[1, pps. 13, 14] estimating that the greatest percentage of all cases observed were between 20 and 30 years of age, although Hodgkin's disease has been reported almost from birth to over 80 years.

Extensive involvement of pleura costalis and pulmonalis by Hodgkin's disease is rare. Sternberg,[3, p.19] Frankel,[5, p.358] Versé, [4, p.332] and Jackson[1] mentioned some cases of their own and cited cases from the literature. They described them as occurring as a miliary chronic indurative or, rarely, as harness-like spreading, coarsely nodulated form.

Pleurisy with effusion in Hodgkin's granuloma is relatively infrequent, but appears, in the opinion of Versé[4] and of Jackson and Parker,[1, pps.13 & 72] to be dependent on the involvement of the mediastinal lymph nodes or on the incidence of tuberculosis, but rarely originates from a granulomatous lesion of the pleura itself. Furthermore, pleural effusions usually are seen late in the disease and "do not appear to have any definite bearing on the prognosis."[1, p.73]

The possibility that characteristic giant cells may be found in the pleural effusion has been mentioned by Versé as a possible aid to diagnosis.

Involvement of the spleen is a common occurrence in Hodgkin's disease.

Remarkable in this case is the complete absence of lesions on the right side and the marked confinement to the left lung and its pleura. The somewhat enlarged fibrotic lymph node that closely adheres to the left bronchus may have some bearing on the atelectasis of the left lung, as well as on the entrance and spreading of the disease. Unfortunately there was no opportunity to make elaborate use of this unique material for research concerning etiology of this condition.

SUMMARY

Autopsy report of a 30-year-old white female who died suddenly with an enormous unilateral effusion caused by extensive pleural lymphogranuloma (untreated Hodgkin's granuloma) is presented.

The process affected only the left thoracic and visceral pleura producing total collapse of the left lung and leaving the right lung and pleura entirely unaffected. There were specific changes involving the paratracheal, mediastinal, and retroperitoneal lymph nodes as well as the spleen.

The course of the disease was rapid and the anatomical structure was not influenced by x-ray or other therapy.

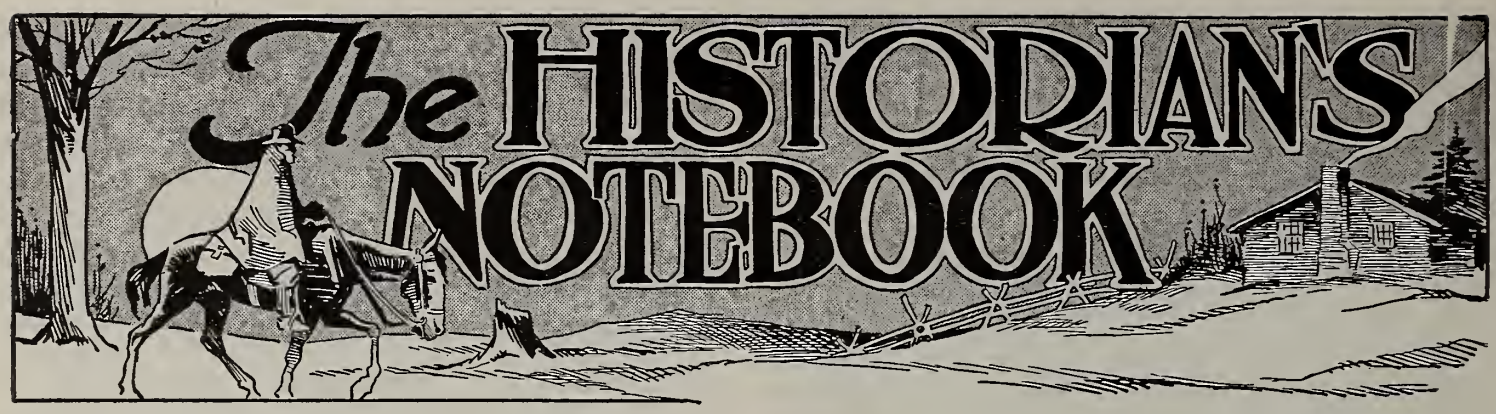
Multinucleated giant cells and eosinophiles were found in the exudate as advanced by Versé as a possible diagnostic aid.

No specific organism could be found. The extracellular and intracellular acid-fast granules resembling organisms noted in the slides seemed to be derived from the granules of the numerous eosinophilic leucocytes.

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Actinomycosis is a rather infrequent endemic disease. Cope stated that wherever there is a microscope and a laboratory this fungus has been found to be a cause of disease. It is the commonest of the systemic fungus infections and occurs in both the one anaerobic and numerous aerobic forms. The aerobic form is so rarely a cause of progressive disease that authorities recommend that only the disease caused by the anaerobic Actinomyces bovis be called actinomycosis and any other of the family take name from the genus Nocardia, i.e., nocardiosis. —Nettrour, The Penn. Med. J., 53:1089, 1950.



The Ohio Anatomy Law of 1881

PART I

LINDEN F. EDWARDS, Ph. D.

ONE of the most prevailing characteristics of legislative bodies in our democratic form of government is their policy of inconsistency. A most noteworthy example of this policy is illustrated by the attitude of our lawmakers during the nineteenth century who demanded of physicians a knowledge of the structure of the human body while at the same time they made it illegal for medical schools to obtain human bodies for dissection by failing to provide for legal acquisition of cadavers. Occasionally, feeble protests like voices crying in the wilderness would be heard from the members of the medical profession. For example, in 1844, Dr. Austin Flint declared that "the position which legislation generally sustains at present toward this subject is truly anomalous. In its requirements for ample knowledge and its penalties for ignorance and mal practice, in effect, it holds the following language to the medical student and practitioner 'you must not fail to make yourself acquainted with the construction of the human machine, composed of a multitude of parts, combined, and variously involved with each other; and if you are not found thoroughly conversant with this intricate pursuit, you render yourselves liable to heavy damages in a civil suit . . . but do not dare to study the constitution of the human body, and the operation of its organs and functions, if you would avoid the pain of punishment by fine and imprisonment'."[1]

In 1849, Dr. R. L. Howard protested that "in this enlightened age, while the community requires of every physician a familiar knowledge of anatomy, it takes from him, by its laws, the only means of acquiring it, and subjects to the severest penalties whoever is detected in procuring, ever so cautiously, the only means of affording that knowledge. The law, everywhere, condemns a man to fines and imprisonments who procures a dead body for dissection; and yet the very community which makes the law, commands him to steal, by their very necessities . . . the medical student is obliged to seek a subject where he can find one, without doing sacrilege to family feelings, or remain ignorant of one of the most important branches by which he is to benefit the human race."[2]

As late as 1878, Dr. Starling Loving bemoaned the fact that "in Ohio the practical study of anatomy is criminal, yet the courts expect the medical witness to know that as well as other sciences when called upon to decide questions involving life, honor and property."[3]

In spite of opposition to human dissection from the ignorant and pious who adhered to a superstition about keeping the body intact and who argued that dissection blasphemously exposed the secrets of nature, and notwithstanding a deep-rooted human tendency to protect the dead, the basic difficulty faced by the medical colleges in the nineteenth century was lack of proper legislation. As we look backward from our vantage point in the twentieth century it's difficult for us to comprehend the stupidity

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of legislative bodies in failing at the very outset to solve the problem of grave robbing by the simple expedient of making it possible for medical schools to obtain dissection material legally.

The first legislative body in the United States to view the problem realistically was that of the state of Massachusetts, which passed an anatomy act on February 28, 1831, making it lawful for boards of health and other specified public officials "to surrender dead bodies as may be required to be buried at public expense to any regular physician for the advancement of anatomical science."[4]

THE ANTI-DISSECTION LAW OF 1831

Oddly enough, the same year that Massachusetts enacted its anatomy law the twenty-ninth general assembly of the state of Ohio, on March 8, 1831, passed "An Act for the Punishment of Certain Offences Therein Named."[5] Section 19 of this act reads as follows:

"That if any person shall wantonly dig or take up any corpse or dead human body, buried or entombed in any cemetery or burying ground, either public or private, or shall attempt to do so; or shall carry away from such cemetery or burying ground, any such corpse or dead body; or shall aid, assist, or be in any way concerned, either in the attempt, or in digging or taking up, or in carrying away such corpse or dead body, as aforesaid: every person offending in either of the aforesaid instances shall, upon conviction thereof, be fined in any sum not exceeding one thousand dollars, or be imprisoned in the cell or dungeon of the county jail, and fed on bread and water only, not exceeding thirty days, or both, at the discretion of the court."

Doubtless, the most enlightened physicians and surgeons of the state bitterly opposed the act of 1831. However, the first concerted voice of disapproval was not heard until 1835 when a general medical convention was held in Columbus. One of the items of business of this convention was the adoption of the following resolution, to-wit:

"1. **Resolved**, That this Convention deem it expedient and proper, to memorialize the Legislature to so amend the criminal law, as to modify or repeal the 19th section of the act entitled "An Act for the punishment of certain offences therein named," passed March 8th, 1831; and further praying the enactment of a law authorizing the dissection of all persons convicted of capital offences, who die either in common jails or the Ohio penitentiary, or that are hanged in pursuance of law.

2. **Resolved**, That a committee of three members be appointed to draft a memorial in the name of this Society, and present the same to the Legislature at its present session, in accordance with the foregoing views.

"Respectfully submitted,
M. Z. Kreider, Chairman."[6]

From 1831 onward for the next fifty years a bitter contest ensued in the Ohio General Assembly between the proponents for rigid and strict laws which curtailed human dissection on the one hand and the proponents for legislation providing legalization of dissection on the other hand. The present paper deals with this see-saw legislative contest and the events which likely precipitated the various acts introduced in the general assembly bearing on these two phases of the anatomy problem.

THE WORTHINGTON RIOT

In December 1839 a riot occurred at the Worthington Reformed Medical College following the discovery that several bodies had recently been exhumed from neighboring cemeteries. The details of this episode have been enumerated elsewhere.[7] However, it is interesting to follow the repercussions of this event.

That the Ohio General Assembly had already been alerted to the charges of grave robbery brought against the faculty and students of the Worthington Medical College is evidenced by the fact that a bill to amend "the act for the punishment of certain offences therein named" was introduced and debate begun in the house of representatives on Monday, December 30, 1839. The bill proposed to substitute for the existing penalty of confinement in the dungeon of the county jail for not more than thirty days for the offenses of removing or concealing dead human bodies, imprisonment in the penitentiary from one to three years.

The following account of some of the debate on this proposed amendment illustrates the fact more forcibly than the present writer could possibly express it, that supposedly rational lawmakers during this period were more swayed by human prejudice and passion than by sane judgment:

"Mr. Morris moved its indefinite postponement.

"Mr. Patterson remarked, that trespasses were committed every year upon the graveyard in the town of Delaware. How long these things were to continue, he could not tell. Enormities of the same kind were committed in the burial ground of this city. These transactions had been committed so frequently, as to call for severer enactments on this subject. In introducing the resolution of inquiry which led to this bill, he had been governed not only by his own feelings, but by what he believed to be the sentiments of his constituents and a large majority of people of the State. An institution, not far from this city, had been charged with taking bodies wherever it could find them—of doing it in daylight, and not merely for its own use, but for traffic. Should we not put a stop to this nefarious business? Should the remains of parents, of children and relations, be dragged from their graves for the use of these institutions? He was aware of that gentleman's opposition to the bill. It was, he supposed, because he was a member of the medical profession. He hoped the motion would not prevail, but that the bill might lie on the table, if the House was not yet satisfied of its necessity.

"Mr. Flood said this offence was, by the exist-

ing law, punishable by fine and imprisonment. This bill proposed to substitute imprisonment in the penitentiary. It was well known that some outrageous instances of this offence had occurred within the year past. He would mention the case of a respectable lady of Washington County, whom he had well known. She had been unfortunate, and became deranged, and was placed in the Lunatic asylum in this city. While there, she sickened and died, and was buried. Soon after her decease, her son came for the purpose of removing the body to Marietta for interment; but, to his horror, found it had been taken away. He procured a warrant, and proceeded to the medical institution at Worthington. The President of that institution denied the right of the officer to search. Search was made; and upon opening a trap door in the center of the building, the first object that met the eyes of the son was the body of his mother with the head mutilated. He had been informed, by a respectable authority, that persons belonging to this institution dug up bodies, not for anatomical purposes only, but for trade. Now, was not an offence like this deserving of imprisonment in the penitentiary? He was astonished that his colleague, (Mr. Morris), who was a physician, opposed it. In his opinion, the bill did not make the punishment severe enough. He would go for a heavier penalty.

"Mr. Morris thought it passing strange—supremely astonishing, that in this age of improvement, when all the arts and sciences and literature were on the advance, a bill should be laid on their desks calculated to operate as a prohibition on the most important science in the range of natural philosophy, and to subject the devotee of science to ignominious punishment. It was a conceded fact, that a knowledge of anatomy was indispensable, a *sine qua non*, in the acquisition of medical science. Without it, the physician could not exercise his profession with credit to himself or comfort to the community. No one would employ a mechanic who did not understand his business, much less would anyone entrust the health of himself or his family to a physician unlearned and unskilled in his profession, destitute of that knowledge which cannot be acquired without anatomical dissection. Mr. M. went at considerable length into details, somewhat technical, to show how much the triumphs of modern improvement in the medical science was indebted to the knowledge of practical anatomy. He would not encourage a sacrilegious violation of the grave, or disregard of surviving friends. Barriers sufficiently strong were already thrown around the habitations of the dead, by laws now in force. A law like this would drive from our colleges poor young men, ambitious of obtaining a knowledge of the profession, and carry into other States fifty or a hundred thousand dollars, annually spent in the acquisition of the medical profession. Our own schools would dwindle, and those abroad reap the benefit we cast away. Physicians were made accountable to the laws for mal-practice, unskillfulness and ignorance. With what consistency, then, could they be denied the means of perfecting their art?"[8]

The bill passed the House on Tuesday, December 31, 1839, yeas 47, nays ten.[9] Mr. West moved to amend the title so as to read, "an act to prevent the study of anatomy and surgery," but this was negatived.

The following day, January 2, 1840, the bill was reported back to the senate and on motion was recommitted to the committee on the judiciary.[10] On February 14, 1840, the committee on the judiciary, to which had been referred the bill to amend the act for punishment of certain offenses therein named, reported the bill back, a majority of the committee recommending its indefinite postponement. The bill was laid upon the table.

Meanwhile there appeared in various Ohio newspapers a "Physician's Notice" signed by thirty Ohio physicians who bitterly protested the pending amendment to the act of 1831, and who threatened reprisals to all legislators voting for the amendment by declaring their refusal to give them medical attention if called upon. They urged other Ohio physicians to take the same stand.[11]

Unusual as this method of attack by the medical profession might appear today, according to present-day ethical standards, nevertheless, it was evidently effective, since the bill in question failed to pass the senate when it came up for final vote on March 21, 1840.[12]

FAILURE OF FIRST BILLS FOR LEGALIZATION OF DISSECTION

On March 9, 1840, Senator Allen introduced a bill to allow subjects for anatomical investigation in medical schools.[13] On March 14, Senator Glover of the committee on medical colleges and societies reported this bill back and recommended its indefinite postponement.[14] This was agreed to. Thus was defeated the first attempt to legalize human dissection in Ohio, and, as we shall see, it was not until thirty years later that a law to encourage the study of anatomy was enacted.

(To Be Continued in January Issue.)

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Income and Other Taxes . . .

Two Major Changes Are Effected for 1950; Other Federal and State Tax Laws Are Summarized; Utmost Care in Filing Returns Necessary

THE big story for 1950, as far as taxation is concerned, is increase in the Federal Income Tax structure, effected by Congress in the face of a mounting preparedness program. Another major change in the tax picture was brought about by revision of the Social Security Act. Other than those two major changes, tax laws remain much the same as those in effect for 1949. The following summary is submitted in order that physicians may apprise themselves of changes and review other tax laws.

Most physicians are in the category of persons who must file returns on (1) Federal Income Tax; (2) Federal Social Security—(a) Old Age and Survivors' Insurance Tax and (b) Unemployment Insurance Tax; (3) Ohio Unemployment Compensation Tax; (4) Ohio Personal Property Tax; (5) Ohio Use Tax; and (6) Ohio Workmen's Compensation Tax. Obligations of the taxpayer in regard to laws governing each of the foregoing are summarized in succeeding paragraphs.

REVENUE ACT OF 1950

The Revenue Act of 1950 does not change the **rate of tax** on individuals, the tax being computed at the same rates applicable to the year 1949. Increased income tax liability of individuals for 1951 and subsequent years is accomplished under the act by removing from the law as to 1951 and later years the **percentage reductions** (of the total tentative tax to arrive at the net amount of tax liability).

Technically, the increased tax burden began with the last quarter of 1950 (the three months beginning October 1, 1950). However, the use of October 1, 1950, as a starting date for the 1950 increase does not mean that income received or accrued after September 30, 1950, is segregated and taxed at a higher rate. The way it works out for the calendar year 1950 is that the tax is computed on the net income for the entire year, but the **percentage reduction** of the total tentative tax is only about three-fourths of what it was in 1949.

For the calendar year 1950 an individual will compute his total tentative tax (normal tax and surtax) at the same rates that applied on 1949 income, but the reduction of the total tentative tax will be smaller than for 1949.

(Special provisions are made for those persons who compute their tax for a fiscal year other than the calendar year.)

The accompanying information in regard to Federal income taxes is based on material supplied to The Journal by Mr. S. F. Noggle, Columbus, for many years chief of Income Tax for the 11th Ohio Internal Revenue District. Every effort has been made to keep it as authentic as possible within the limits of brevity. Physicians are advised, nevertheless, to obtain advice and assistance in the preparation of their returns from competent tax authorities or from staff members of the office of District Collectors of Internal Revenue.

For the **1950 calendar year** the percentage reductions on the tentative tax are as follows:

13 per cent of the first $400 of tentative tax;

9 per cent of that part of the tentative tax in excess of $400 and not in excess of $100,000;

7.3 per cent of that part of the tentative tax in excess of $100,000.

The 1950 Act does not change the personal exemptions and dependency credits. An exemption of $600 may be claimed for each dependent of close relationship. To claim dependency, the taxpayer must have furnished over half of the actual amount used for the dependent's support in the taxable year. A dependent cannot be claimed if he has a gross income of $500 or more for the taxable year.

An additional personal exemption of $600 is allowed for those who reach the age of 65 and to those who are blind. The additional credit applies both to the taxpayer and/or to his spouse (but not to other dependents).

The 1950 Act does not disturb the system of splitting the income of married couples adopted in the Revenue Act of 1948. In effect this provision places individuals in non-community property states—for example, Ohio—on the same basis for income tax purposes as those living in community-property states. That is, a husband and wife in many cases may effect substantial reductions by splitting their income on a joint return. On such a joint return, the taxable income (adjusted gross income less optional standard or ordinary deductions and less exemption credits) is then divided in half

and a tentative tax computed on half of the income.

In addition to the reduction in rates because of the computation being made only on half the income, credits are provided after arriving at the amount of the tentative tax. There is to be deducted 13 per cent of the first $400 of such tentative tax, or $52. If the tax is in excess of $400, the deduction will be $52 plus 9 per cent of the amount in excess of $400. The net tentative tax is then multiplied by two to arrive at the total tax liability.

WITHHOLDINGS

The new law increased the withholding rates, changed the definition of "wages" and added a new provision in regard to statements furnished members of the Armed Forces.

A new wage bracket withholding table is applicable to wages paid on or after October 1, 1950. If wages are paid on or after October 1, the new tables apply regardless of when wages were earned.

The rate for withholdings was increased from 15 to 18 per cent (after personal exemptions of $600 for the taxpayer and each dependent).

Enlisted personnel and all classes of warrant officers are exempt from tax on the pay they receive from active service in the Armed Forces of the United States for any month during any part of which they served in a combat zone, after June 24, 1950, and before January 1, 1952. The first $200 of monthly compensation received by commissioned officers for similar service is also exempt. The exemption does not extend to pensions and retirement pay.

A *Supplement to Employer's Tax Handbook* issued by the Bureau of Internal Revenue gives new tables for tax withholding rates effective October 1, 1950.

REPORT OF FUNDS PAID

As in previous years, it is necessary to report salaries of office assistants and other employees whose salaries are subject to the withholding tax. As in previous years, payments in excess of $500 made during 1950 for interest, rents or commissions, not subject to withholdings and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 15, 1951, to the Commissioner of Internal Revenue, Processing Division, Kansas City, Mo.

FORMS AND PAYMENTS

Every person whose gross income for 1950 was $600 or more must file certain income tax returns with the Collector of Internal Revenue for his district, not later than March 15, 1951.

Every physician in private practice who comes within the provisions of the Income Tax Law must do the following:

1. File a complete income tax return for 1950. He should use Form 1040, either the short form or the long form. The short form may be used only when the adjusted gross income, minus allowable business deductions, is less than $5,000 and when the tax is taken from the table. The long form must be used when the income is $5,000 or more or when the taxpayer wishes to claim credit for non-business deductions, such as charitable contributions, personal interest or taxes.

2. Pay the difference, if any, between the income tax paid during 1950, based on the estimated return for 1950 which he filed during that year and the amount of the tax computed on his final return for 1950 filed on or before March 15, 1951. If he has overpaid, the excess amount will be refunded or credited against future tax payments. Amounts refunded carry interest at six per cent from March 15, 1951, to date of payment.

3. File a declaration of estimated tax for the year 1951, and pay one fourth of the estimated tax for 1951, the balance payable quarterly thereafter. Blanks for filing the 1951 return will be mailed to taxpayers of record by the district collectors of internal revenue. If estimated returns for 1951 are based on 1950 income and the tax computed at the 1951 rates, no penalty will be assessed even though the estimated tax is understated by more than 20 per cent.

DISTRICT OFFICES AND DISTRICTS

Income tax payments and returns must be made at the office of the District Collector of Internal Revenue for the district in which the taxpayer has his legal residence. There are four internal revenue districts in Ohio. The counties comprising each district follow:

For the Columbus District (Ohio 11th) Collector of Internal Revenue, Federal Building, Water and Gay Sts., Columbus; comprising the folowing counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Collector of Internal Revenue, 262 Federal Building, Cleveland; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Collector

of Internal Revenue, Customs Building, Cincinnati; comprising the following counties:

Brown, Butler, Clark, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Collector of Internal Revenue, Toledo; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Darke, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

ADJUSTED GROSS INCOME

Individuals who are employed and receive a salary have no difficulty in arriving at the amount of their adjusted gross income. The total salary received plus any amounts which might be received from interest or dividends would in such cases constitute the gross income.

The physician has more difficulty in arriving at his adjusted gross income. From the amount of his cash receipts—if he reports income on the basis of cash received and disbursements, or on the amount of total charges if he uses accrual method of reporting his income—he may deduct all items of expenditure necessary in earning his income. These items are described in more detail in the following sections.

DEDUCTIBLE BUSINESS EXPENSES

Office Rental—If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he **cannot** claim deduction for office rent. However, he is entitled to claim depreciation on that portion of the property occupied as an office.

Automobile—The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, car fare, etc., while on professional calls, may be deducted.

Depreciation may be deducted on an automobile used in professional business. The depreciation which should be deducted annually is figured by dividing the cost price of the machine by the number of years of its usefulness. On the assumption that the useful life of an automobile is four years, the government allows 25 per cent of the cost price for depreciation each year. If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the amount of time the car is used for professional purposes. If a physician possesses two cars, each of which is used partly in professional business, the deductible depreciation on each car should be computed on the basis of the amount of time each car is used for professional purposes. In other words, if an automobile is used only partly for business purposes, depreciation may be deducted only on a proportionate part thereof, the amount of depreciation depending on the amount of time the machine is used in professional business.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is not due to the willful act or negligence of the taxpayer, is deductible loss in the computation of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials should call on them for written records to show the mileage traveled by them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted. Expenses incurred in taking graduate courses have been held **not** to be deductible.

Traveling Expenses—Traveling expenses necessarily incurred by a physician on professional calls and in **attending medical conventions for a professional purpose** are deductible from gross income.

Salaries and Wages—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

Medicine, Supplies, Etc.—Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals and other supplies "consumed in the using" and necessary to operate the office may be deducted.

Equipment, Furniture, Library, Etc.—Cost of surgical instruments and laboratory appliances of more or less permanent value may not be deducted but a percentage of the purchase price may be deducted annually under a depreciation account. The same rule applies to office furniture and books purchased for the physician's office library. If improvement to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed else-

where in the return, claim should not be made for depreciation.

General Office Expenses—The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

Debts—If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (i. e., all fees, either cash or account are included in income reported for tax purposes) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using the latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

Taxes and Licenses—All state and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer upon his interest as shareholder of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible. Taxes on one's own home are not to be considered as business expenses, such taxes being allowable as ordinary deductions only. All license fees which the physician is required to pay, including narcotic tax and local occupational taxes, are deductible. The cost of an automobile license, unless the car is used exclusively for business, is to be taken as an ordinary deduction only. The tax paid on telephone bills, if the telephone is used for business only, is deductible as a business expense. This would apply to office phones. The tax paid on other telephone bills would be deductible only as an ordinary deduction. Federal taxes on amusements, club dues, furs and luxuries are not deductible for Federal income tax purposes.

Federal Old Age Benefits and Unemployment Compensation Taxes paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible in returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. Social Security taxes withheld by an employer are not deductible by the employee in computing his tax liability.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Sales Tax Payments—The sales tax paid in connection with purchase of items used in business become a part of the cost thereof and as such are deductible as business expenses. Other amounts expended for sales tax are ordinary deductions and not to be taken as business expenses.

Ohio Gasoline Tax—This tax is deductible to the extent of four cents per gallon. However, if a physician has already included cost of gasoline as part of his business expenses, the tax is not again deductible. The tax paid on gasoline not used in business is deductible as an ordinary deduction.

Interest—Amounts paid as interest on business indebtedness may be taken as business expenses. Interest items paid on personal indebtedness are deductible only as ordinary deductions. Interest paid to carry tax free securities may not be deducted.

Losses by Fire and Theft—Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair, and the cost of the repair is claimed as a deduction.

Legal Expenses—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is **not** deductible.

ORDINARY DEDUCTIONS

In addition to items mentioned in the foregoing paragraphs which would not fall under the category of ordinary deductions, the following may be taken under that heading:

Contributions, Gifts, Etc.—It is permissible to deduct from gross income, contributions made to charitable, religious, educational and scientific organizations, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting to influence legislation, to an aggregate amount not to exceed 15 per cent of the adjusted gross income.

Medical and Dental Expenses—Deduction is

permitted for extraordinary medical-dental expenses paid during the year, not compensated for by insurance or otherwise, which are in excess of five per cent of the adjusted gross income. In the case of a husband and wife filing a joint return, the expenses are not deductible unless they exceed five per cent of the aggregate adjusted gross income of both. The maximum allowable deduction on a joint return is $2,500 plus $1,250 for each dependent listed on the return, not to exceed two. The maximum deduction is $5,000. The maximum allowed for a single person with no dependents is $1,250. The term "medical care" as used in the act, is broadly defined to "include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accidents or health insurance)."

In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and the amount. It should be noted that this will furnish the Internal Revenue Department with data which can be used in checking returns filed by physicians and dentists—another reason why they should keep accurate records and compile their returns carefully.

OPTIONAL STANDARD DEDUCTIONS

The optional standard deduction permitted in lieu of listing amounts paid for contributions, interest, taxes, and other ordinary deductions is 10 per cent of the adjusted gross income, but not in excess of $1,000.

DEPOSIT OF WITHHOLDINGS

An employer who accumulates as much as $100 per month for the purposes of income tax liability and F. I. C. liability (employer's and employee's shares) shall take these funds with Form 450 to a bank and deposit them. The bank transmits this form to the Federal Reserve Bank in Cleveland for validation, after which it is returned directly to the employer. The depositary receipt, Form 450, is then eligible for use.

SOCIAL SECURITY TAXES

The Federal Social Security Act embodies laws pertaining to Old Age and Survivors' Insurance and Unemployment Insurance. Because the procedures for paying these taxes are different, they are discussed here under separate headings.

Extensive changes in the whole Social Security structure were effected by passage of H. R. 6000, signed by the President on August 28, 1950. These changes have been incorporated into the following paragraphs on the subject.

Under the new provisions for coverage of self-employed workers, physicians are specifically excluded, as are certain other professional persons and farmers.

New provisions for coverage go into effect on January 1, 1951. Increased benefits went into effect as of September 1, 1950.

ADDITIONAL EMPLOYEES COVERED

Domestic workers in private homes who are employed by a single employer for at least 24 days in a calendar quarter for which they receive wages of at least $50 are covered. In general, if a person has a maid or other domestic worker for one day in the week, she does not come under provisions of the Act; if a person has such a worker for two or more days in the week, she must be covered. Domestic workers in farm homes come under the same provisions as farm workers.

A farm worker becomes eligible after he works continuously for one farm operator for three months and then continues to work for him on a full-time basis on at least 60 different days every three months and earns $50 or more in cash wages every three months.

Only cash is considered in the wages paid to domestic or farm workers, not wages paid in kind.

Household or farm workers are reported to the Collector of Internal Revenue on Form 941. If the household employer is already making Social Security reports on Form 941 for employees in his professional practice, he may report his household employees on this same form.

Many other types of employees are covered under the new act. The Federal Security Agency estimates that an additional ten million workers may be brought under its provisions —bringing the total number covered to about 45 million, or about three-fourths of the nation's paid workers.

OLD AGE AND SURVIVORS' INSURANCE TAX

The Old Age and Survivors' Insurance Tax is payable by every physician who employs **one or more persons in his office.** An increase in the rate of payment became effective on January 1, 1950, to the effect that the employer must deduct 1½ per cent of the employee's wages, and must contribute a like amount himself. This same rate was carried over under the new act and continues through 1953. **Through 1950,** the amount is deducted and contributed on the first $3,000 of each employee's wages. **Beginning January 1, 1951, the rate will be deducted and contributed on the first $3,600.** The tax return and informational return, combined in one report, is to be filed quarterly. The tax must be paid and the return filed prior to April 30, 1951, for the months of

January, February and March, 1951 in the office of the District Collector of Internal Revenue, and quarterly thereafter, payable the month after the quarter ends.

FEDERAL UNEMPLOYMENT TAX

The Federal Unemployment Insurance Tax applies only to employers who have had **eight or more persons** on their payrolls on 20 or more days in the Calendar year, each of the 20 days being in different calendar weeks. It is payable to the Collector of Internal Revenue by January 31 for the previous year. The gross tax is three per cent on all individual wages up to $3,000, and is paid exclusively by the employer —the employee making no contribution. (The $3,000 limit is retained for the unemployment tax and is not to be confused with the $3,600 maximum under the old age and survivor provisions.) A credit not to exceed 90 per cent of this tax is allowed on all payrolls which were reported to the state unemployment compensation agency (see under Ohio Unemployment Compensation Tax) and the state tax paid by January 31. If an employer has paid his state unemployment tax in full, the Federal tax is reduced to three-tenths of one per cent.

OHIO UNEMPLOYMENT COMPENSATION TAX

In general, employment of **three or more persons** in any one day renders the employer liable for this tax. There are certain exceptions. A physician who is in doubt as to his liability, therefore, should request clarification from the Bureau of Unemployment Compensation, Columbus.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau. The tax rate is established for each employer annually according to a table in the law which is based on the ratio the tax paid by the employer bears to the benefits paid to his former employees and chargeable to the employment the claimants had with the employer. This rate starts at 2.7 per cent and may be reduced to as low as three-tenths of one per cent. Only the first $3,000 paid by any employer to any one individual within a calendar year is taxable.

OHIO WORKMEN'S COMPENSATION LAW

Every employer of **three or more employees** is required under the Workmen's Compensation Law of Ohio to file during the month of January a statement containing the following information: The number of employees employed during the preceding year, the number of such employees employed at each kind of employment and the aggregate amount of wages paid to such employees. The employer must pay into the fund a premium based upon occupational hazard of the job in which the employee is engaged. An employer of less than three persons, although not obligated to do so, may elect to pay premiums into the funds on employees.

OHIO SALES AND USE TAX

Section 5546-2 of the General Code levies an excise on each retail sale made in Ohio of tangible personal property.

The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department. **However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Department, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by April 15, 1951, for purchases, during the period January 1 to March 31, 1951, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."**

Rule 102 of the Ohio Tax Commissioner applies specifically to physicians and dentists. It reads: "Physicians and dentists are the consumers of the various items of tangible personal property which they use in the rendition of their professional services and the tax will apply upon their purchase of all items of tangible personal property, including equipment. The tax does not apply to the fee for professional services rendered by physicians and dentists. If physicians and dentists apart from their professional services are engaged in selling, to the public such articles as medical supplies, mouth washes, dentifrices and the like, they are vendors and must procure a vendor's license and collect the tax on all such sales."

OHIO PERSONAL PROPERTY TAX

There have been no fundamental changes in the Ohio Personal Property Tax provisions.

Returns under the Ohio Personal Property Tax Law must be made between February 15 and March 31 annually. One half the amount of the tax is paid when the return is filed, and the other half is due September 20.

The State Tax Commissioner is currently conducting a campaign to increase efficiency in the collection of this tax, and penalties are being assessed against those who have been delinquent or have failed to declare personal property for taxation.

All intangible personal property in possession of a physician on January 1, 1951, and tangible

personal property (not real estate) used by him in his business, which is subject to taxation under the Ohio law, should be listed on the return which should be filed with the county auditor between those dates. Form 910 is used by individuals and partnerships, and Form 930 by corporations.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies, etc. Such tangible property should be listed at its book value. A depreciation of 10 per cent annually from cost will be allowed until such equipment reaches a value of 30 per cent of cost which value should be used as a utility value.

Such returns should be made in duplicate. The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

One of the complicated provisions of the tax law is that involving the listing of credits which are taxable at 3 mills on the dollar and which involves the computation of accounts receivable.

Accounts receivable are to be listed in accordance with Section 5389 of the General Code.

As defined in Section 5327 of the law, credits "mean the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

In listing his current accounts receivable, the physician should note after each account what he considers the value of the account. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise, it should be listed at 75 per cent, 50 per cent, 25 per cent, 10 per cent, etc., of its full face value, or of "no value" in case that is considered the "actual value" of this account. The total of these estimates is the total to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts since in his 1950 return he would be permitted to return as of "no value" accounts receivable which he listed in 1949 but no part of which was collected during the past year. Moreover, it permits a physician to depreciate the actual value of accounts returned in 1949 but which have decreased in actual value during the past year.

A. M. A. Announces Standards for Approval of Sun Lamps

The Council on Physical Medicine and Rehabilitation of the American Medical Association recently announced its requirements for the performance and advertising of sun lamps in order to obtain the council's Seal of Acceptance.

"These requirements," it was explained by Howard A. Carter, secretary of the council, "are designed to protect the public against unwarranted claims of the curative and beneficial values of sun lamps."

Natural sunlight contains a band of wavelengths in the extreme ultraviolet, extending from about 2,900 to 3,200 angstroms, that is specific in preventing and curing rickets and also in producing vitamin D, reddish skin and tan. With the exception of the tanning reaction, which extends to about 3,700 angstroms, solar radiation of wavelengths longer than about 3,200 angstroms has been found to be of no specific biologic action.

To comply with the requirements for minimum intensity, a sun lamp must generate sufficient ultraviolet energy to produce a minimum perceptible erythema (reddening of the skin) on the average untanned skin in not more than one hour at a minimum distance of two feet. If the intensity is less than this, the council is of the opinion that the radiation is too weak to have any significant prophylactic effect against rickets. An operating distance of two feet, it adds, is too short for use in a nursery.

"In accepting sun lamps, the council requires physical evidence of their production of energy from 2,800 to 3,200 angstroms in wavelengths at an intensity which is adequate and safe for use by laymen," said Mr. Carter.

"It has been demonstrated both clinically and experimentally that adequate ultraviolet energy between 2,800 and 3,200 angstroms plays an important role in deposition of calcium and may prevent rickets. There is no warrant for the claim, however, that ultraviolet rays will insure normal tooth structure or that ultraviolet rays will prevent dental caries. Direct exposure of the skin to ultraviolet rays from the sun or from artificial sources results in the formation of vitamin D within the organism, but the council cannot recognize statements or implications that vitamin D has all the beneficial effects of exposure to sunshine.

"Advertising claims for sun lamps containing statements that exposure to ultraviolet radiation increases or improves the tone of tissues of the body as a whole, stimulates metabolism, acts as a tonic, increases mental activity or tends to prevent colds are not acceptable."

Rights of Limited Practitioner . . .

Strong Decision by Judge Emmons, Akron, Holds He Cannot Prescribe Or Use Drugs; 'Minor Surgery,' 'Drugs,' Defined; Board Rules O. K.

A DECISION of far-reaching importance—citing what mechanotherapists and other limited practitioners of that category can and cannot do under the license granted to them under the provisions of the Ohio Medical Practice Act and upholding the rules and regulations of the State Medical Board which govern such practitioners, was handed down recently by Common Pleas Judge Claude V. D. Emmons, Summit County, (Earl Botkin, appellant vs. State Medical Board of Ohio, appellee).

In affirming the judgment of the State Medical Board in revoking the license of Earl Botkin, Akron, to practice mechanotherapy for violating the rules and regulations of the Board and Section 1274-3 of the Ohio General Code, Judge Emmons set forth the following conclusions in his written opinion:

FINDINGS OF THE COURT

1. A licensed mechanotherapist must not prescribe or administer drugs of any kind in performing minor surgery.

2. Minor surgery which he is permitted to perform must be an operation within the limits of mechanotherapy.

3. Vitamins and liver extract, as well as sulfathiazole ointment and metycaine, are drugs within the meaning of the statutes of the State of Ohio.

4. The order of the State Medical Board is supported by sufficient evidence and is not contrary to law.

5. The rules and regulations of the State Medical Board of Ohio pertinent to the within action are not invalid or repugnant to the provisions of the Constitution of Ohio and are not contrary to the laws of this State.

6. The statutes drawn in question in this action are not invalid for indefiniteness, ambiguity or uncertainty and are not repugnant to the provisions of the Ohio Constitution and the laws of the State of Ohio.

SUMMARY OF FACTS

The facts in this case are briefly these: On June 12, 1946, Botkin, who held a state license to practice mechanotherapy, was charged by the State Medical Board with using thiamine chloride, liver extract, sulfathiazole ointment, nupercainal, quinocaine, metycaine and otozole, and that the use of these remedies was in violation of the rules and regulations of the Board governing limited practices and violative of the provisions of section 1274-3, Ohio General Code.

Testimony was submitted to the Board that Botkin admitted using the drugs referred to and that he did not testify in his own behalf nor introduce testimony to deny the charges at the hearing before a referee appointed by the Board.

On August 3, 1948, a copy of the opinion of the referee was filed with the State Medical Board, which Board adopted the recommendations of the referee and on October 5, 1948, entered an order revoking the license issued to Botkin and from which order he filed an appeal in the Summit County Common Pleas Court.

EXCERPTS FROM DECISION

Following are additional pertinent excerpts from Judge Emmons' decision, excluding certain references to sections of the General Code and court decisions which were cited in the briefs filed by Botkin and the State Medical Board and considered by Judge Emmons in reviewing the case:

At the outset it will be noted that the power to revoke a limited practitioners' license is governed by sections 1274-6 and 1275 Ohio General Code.

Part of the general rules and regulations of the Board governing limited practitioners is as follows:

> "The certificate does not permit the holder to treat infectious, contagious or venereal diseases nor to prescribe or administer drugs or to perform major surgery."

The appellant complains about the indefiniteness of the charge made by the Secretary of the Board, but it is an accepted fact that charges made by a ministerial body do not have to be in the same form for exactness and definiteness as do the pleadings in a court of law or equity.

The appellant was charged with prescribing and administering certain drugs, and if these, or any of them, are found by substantial evidence to be drugs, and the statute is not invalid for vagueness, or the delegation of the powers to the Medical Board is not unconstitutional, or their orders *ultra vires*, then the Board could well find the appellant guilty of the violations of the rules and regulations of the Medical Board and also section 1275 Ohio General Code, for the reason that the appellant would have been

acting contrary to the rules and regulations of the Medical Board and also acting grossly immorally under the statutes of Ohio, which term, to this court, means wilfully unjust in his limited practice of medicine or surgery.

The principal questions for the Court's consideration are as follows:

1. Are the pertinent rules and regulations of the State Board of Medicine invalid, *ultra vires* or unconstitutional?

2. Are the General Code sections 1274-1 and 1274-3 invalid for indefiniteness, uncertainty and ambiguity?

3. May the appellant, a duly licensed mechanotherapist, prescribe or administer in the performance of minor surgery any or all of the following: sulfathiazole ointment, metycaine, nupercainal, quinocaine or otozole, and in his limited practice may he prescribe or administer vitamins or liver extract?

RULES ARE VALID

Are the pertinent rules and regulations of the State Medical Board invalid and ultra vires or unconstitutional?

This question was asked and an attempt made to answer it in the appellant's brief wherein he cites numerous cases, all of which are untenable because in his cited cases the inherent police power was not present, while in this case it is.

The right to practice limited or unlimited branches of medicine or surgery is not an inherent or God-given right, nor is it a right once obtained that is perpetual. It is a right given to some one who, because of his training, education and experience, has been found to have the qualifications to perform in his respective field, subject, however, to the laws and rules and regulations governing that right. When one is given a license to practice in a limited branch of medicine or surgery, that one impliedly agrees to conform to and abide by the laws, rules and regulations prescribed for his particular branch of medicine or surgery, the nonperformance of which will result in disciplinary measures such as suspension or revocation of license.

Counsel for the appellant contends that section 1274-1 of the Ohio General Code, which states that the Medical Board shall establish rules and regulations governing such limited practice, shall rightly be construed to mean that the board shall have the right to establish rules and regulations for the administration rather than enlarging or restricting the statutory laws.

"Govern" means to regulate by authority.

Did the Board in this instance enlarge or restrict the statutory laws? What do we find in this case?

It is to be noted that the last paragraph in section 1274-3 and the rules and regulations of the State Medical Board are practically the same. They both set out a prohibition therein whereby limited practitioners cannot use drugs or practice major surgery, so that by reading the intention of the legislature into the rules and regulations of the State Board it makes it a violation for using drugs, and is such a violation that the practitioner's license could be revoked, and it is not conferring a vagrant or unconfined discretion upon the State Medical Board for the legislature has established a standard of practice and canalized that Board's discretion.

The right given by the legislature by statute to the Medical Board was a right that was a proper grant under the exercise of police powers, and such as is a constitutional investment, and the rules and regulations pertaining to the instant case are valid and not ultra vires.

LAW VALID AND NOT INDEFINITE

Are General Code Sections 1274-1 and 1274-3 invalid for indefiniteness, uncertainty and ambiguity?

The appellant claims that since the term "drug" is not defined in the statute or in the rules and regulations the term then becomes vague, indefinite, uncertain and ambiguous.

It is the contention of the appellant that the evidence clearly indicates that a great uncertainty exists even in the minds of medical men, and then proceeded to quote the testimony of Deitrich, who is the inspector for the Medical Board, but he is not qualified to speak on the subject of drugs since he is not a doctor, pharmacist or a chemist.

In this instance Deitrich was expressing a personal opinion as an investigator, and the Court does not consider this testimony effective as the questions propounded to him, in fact, are such as would make him interpret the rights of a mechanotherapist under the law, which province is not his.

It is true that Dr. Platter, the secretary of the Medical Board, testified that a chiropodist under the rules and regulations of the Board prior to the amendment of section 1274-3 Ohio General Code, was permitted to use drugs in his limited practice, however, the Court is not passing upon the right that they had at that time, whether it was under the proper exercise of police power or whether the Board arbitrarily discriminated against the other branches of limited practitioners—that question is not before the Court.

So regardless of an added right that the chiropodist formerly had under the rules and

regulations of the Board, the rights of Botkin would not be decreased or increased.

DEFINITION OF "DRUG"

The term "drug" is defined under the pharmacy laws of this state. Section 1296-1, paragraph 2, is as follows:

> "The term 'drug' or 'pharmaceutical preparation' means (a) articles recognized in the official United States Pharmacopoeia, or official National Formulary, or any supplement to either of them, intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals; and (b) all other articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals; and (c) articles (other than food) intended to affect the structure or any function of the body of man or other animals; and (d) articles intended for use as a component or any articles specified in clause (a), (b), or (c); but does not include devices or other components, parts or accessories."

The term "drug" as this Court views it, cannot have a different and varying definition under the heading of Pharmacy Laws than it would have under the Medical Board laws. One works in conjunction with the other, as the druggist supplies the doctor, and the definition of the term "drug" should be compatible one with the other.

The Court is not obligated to read only the sections of the statute that are contained under a separate heading and to reconcile them alone, but all statutes incident to and which have any bearing on a question should be read together and interpreted in the light of common understanding and reason.

So while the Medical Practice Act does not have the term "drug" defined, neither do we find a definition for it under the rules and regulations of the State Medical Board, the Court does have the right to accept and should recognize the definition of that term under the Pharmacy Laws of this state, as that section is *in pari materia* with the provisions of the Medical Practice Act, and the legislation is presumed to be consistent and harmonious in the enactment of these laws.

Assuming for the purpose of argument that there was no definition of the word "drug" appearing in the statutes of Ohio or in the rules and regulations of the State Board, the Court must look then to the common conception and meaning of that word as it is understood in the profession in which that word is commonly and professionally used.

Dr. Sollman, a professor emeritus of Western Reserve University and a man recognized as one well qualified to speak in medical circles, defines drug as "a substance that is used in the treatment or prevention or diagnosis of disease." This definition is of substantial clarity that no confusion could result, nor is that definition unlike the definition contained in the statute under the Pharmacy section.

The Court, therefore, cannot agree with the appellant that section 1274-1 and 1274-3 are invalid for indefiniteness, uncertainty or ambiguity.

MAY NOT USE DRUGS

May the appellant, a duly licensed mechanotherapist, use any of the following remedies in the performance of minor surgery; sulfathiazole ointment, metycaine, nupercainal, quinocaine or otozole, and may he prescribe or administer vitamins or liver extract?

The fact that the appellant is charged with administering or prescribing all of the above styled items does not make it necessary that all such facts be established. Were the fact established by evidence that he administered one or prescribed one of the above remedies, and that that one item was a drug, the charge against the appellant would be sufficiently proved.

It must be remembered that the appellant did not take the stand to deny the fact that he told Dietrich that he had administered or prescribed all of these items to his patients, and therefore that fact, standing unrebutted, the Referee and the Board had the right to accept this testimony of Dietrich's as the truth.

Were these remedies or materials "drugs" such as were intended by the legislature and the Medical Board?

Dr. Sollman testified unequivocally that sulfathiazole ointment, metycaine, liver extract and thiamine chloride were drugs but that the other substances were not known to him. His testimony, as the Court has already indicated, was not rebutted.

PROHIBITION UPHELD

At first blush to say that a limited practitioner of medicine or surgery should not be allowed to prescribe or administer vitamins or liver extract for a physical deficiency seems rather farcical, for immediately one realizes that these items can be purchased generally without prescription. **Upon meditation, however, one must necessarily conclude that this prohibition is not an absurdity, for some one in whom you place your future health and in whom you put your trust should be a person who is qualified to speak, to comprehend the nature of your deficiency and to know the necessary prescription therefor.** Since Botkin is a limited practitioner it is presumed that he is not qualified or versed

in the use of vitamins or liver extract, even though he may well be. However, the line must be drawn somewhere, and the legislature has seen fit, from the standpoint of public safety, to say by legislation that practitioners of mechanotherapy shall not administer or prescribe drugs, regardless of their knowledge. **And since the court concludes that vitamins and liver extract are drugs, such then cannot be prescribed or administered by limited practitioners.**

By statute 1274 Ohio General Code osteopaths were given the express authority to use anesthetics and antiseptics, and 1274-3 as amended gave chiropodists the right to use such drugs as are necessary to such practice as are set out in the rules and regulations of the State Board. Thus, if by implication one would say that the mechanotherapist had the right to use drugs to perform minor surgery, that thought is definitely expelled by making an exception by giving osteopaths and chiropodists that right, but no others of the limited practice.

The appellant suggests that since his practice was limited only by the prohibition not to prescribe or administer drugs or perform major surgery he could, therefore, perform operations for all minor surgery.

To perform various types of minor surgery it was testified that local anesthetics and antiseptics were a necessary adjunct to successful operations, and therefore Botkin concluded that since he is entitled by implication to perform minor surgery, and a necessary adjunct to some cases of minor surgery is local anesthetics and local antiseptics, he therefore by law is permitted to use them in his limited practice.

MINOR SURGERY DEFINED

What then can the appellant herein do by way of minor surgery?

He is a mechanotherapist, and mechanotherapy is defined in the rules and regulations of the State Medical Board as being the use of manual, physical or mechanical measures for the treatment of disease, but such physical or mechanical measures shall not include the use of X-ray or radium for therapeutic purposes. That definition in itself sets out just how far the appellant can go in his practice.

It impresses the Court that the mechanotherapist, under the right by implication given by statute, is allowed to practice minor surgery, but must be such as is accomplished by massage or other similar means, either manually or mechanically, and he can go no further.

Legislative enactments must be so construed as not to present an absurdity.

ARGUMENT ERRONEOUS

Can a court conscientiously say that while the legislature by fiat has prohibited limited practitioners the right to prescribe or administer drugs, but since they might practice some minor surgery that therefore the legislature, even though it has spoken clearly, did not mean what it said and that drugs can be used, since in some instances they are considered a necessary adjunct to minor surgery? **This Court believes that such a pronouncement would be unconscionable and erroneous, and it would be establishing a right by implication in the face of expressed legislative restriction and prohibition.**

HEALTH OF PUBLIC AT STAKE

Botkin is presumed to have known the law and, therefore, the limits of his practice as a mechanotherapist, and **if he were dissatisfied with these limits he should have qualified for an unlimited practice, but as long as he has only a limited license he cannot transgress into the field of unlimited practice.**

The unlimited medical profession guards zealously their legal rights against the trespass and encroachment of others, and rightfully so, for they sacrificed many years of their lives in qualifying for this very highly skilled profession, and if that right were not guarded by law or the profession, the health and welfare of the people of Ohio would be constantly in jeopardy.

Here we are dealing with the very lives of people, generally treasured above all things, and the legislature, by its exercise of police power has the right to adopt precautionary measures governing the practice of medicine and surgery to the end that, in so far as humanly possible, the lives and health of the citizens of this state will be given the greatest possible safeguard.

American College of Surgeons Elects

Dr. Elmer R. Arn, Dayton, and Dr. B. Noland Carter, Cincinnati, were elected to three-year terms on the Board of Governors of the American College of Surgeons at the annual meeting of the organization in Boston, October 26.

Among officers elected are: Dr. Alton Ochsner, New Orleans, president-elect; Dr. Thomas H. Lanman, Boston, first vice-president; and Dr. Joel W. Baker, Seattle, second vice-president. Officers will be installed at the 1951 Clinical Congress in San Francisco, dates of which will be announced later.

Two clinics, one on "Surgical Principles of Pelvic Relaxation," and the other on "Hysterectomy—Indications, Physiological Principles and Technique," were given by Dr. John C. Burch, Nashville, Tenn., at the October meeting of the Dayton Surgical Society.

Civil Relief Act . . .

Those Who Go Into Service Are Reminded That Their Rights Back Home May Still Be Protected If They Apply Under World War II Provisions

OHIO physicians who are now on active duty with the armed forces, or who may be called may be interested to know that they can secure coverage under the Soldiers and Sailors Civil Relief Act of 1940.

The law, which was intended to protect persons in service during the last war, is still in effect as amended in 1942. The law is mainly self-executing since there is little provision for administration. This makes it necessary for the individual to seek protection under its provisions. The law is not automatic, although application for coverage by its provisions may be made at any time, providing proof of active military service can be provided.

The law provides for temporary or long range relief for servicemen from: Installment contracts on household goods, automobiles and personal property; mortgages on home or business loans (V. A. included) or homesteads; premium payments on commercial insurance policies (National Service Life Insurance is not covered) and rent payments for housing occupied by the servicemen's dependents.

V. A. LOANS COVERED

T. B. King, director of the V. A. Loan Guarantee Agency, recently said all V. A.-guaranteed loans are covered by the provisions of the act, and accordingly no foreclosures can be made while the borrower is in service. Mr. King said it was the intention of the V. A. to "encourage the extension of the modification of the terms of the loan by a postponement of all or part of the monthly payments." But he emphasized that the lender and the veteran must reach an agreement before the V. A. will recognize any adjustments.

If an agreement cannot be reached otherwise, a court must settle the dispute and make proper adjustments—giving the serviceman full protection under the provisions of the Soldiers and Sailors Civil Relief Act.

All men called up, whether veterans or not, should seek legal advice in securing coverage under the act. Recommended proceedure in securing coverage is to first seek competent legal counsel, second contact creditors and advise them of entrance into armed service, and make whatever arrangements possible with them.

Normally attorneys charge a fixed minimum fee for processing establishment of claims under the act. To claim relief under the act the claimant should, under the direction of his attorney, sign an affidavit to the effect that he is called into military service and seeks relief under the Soldiers and Sailors Civil Relief Act. In most areas the bar associations have a set-up to handle this service without cost in cases of need.

RIGHTS ENUMERATED

Outlined are the basic points of the law:

1. **Eviction**—If rent of premises used chiefly as a dwelling is not over $80.00 a month, it is a misdemeanor to attempt to evict the dependents of one in military service without permission of a court, which may stay eviction for not over three months.

2. **Lease Termination**—Leases made before service may be terminated upon written notice to the landlord, effective 30 days after the next monthly rent date.

3. **Taxes**—(a) Payment of Income Taxes before or during service may be deferred, without interest, until six months after service ends if the person's ability to pay is materially impaired by his service.

(b) **Taxes on Real Estate and Personal Property**—No tax sale or other proceedings shall be instituted against persons in the service for delinquencies on taxes and assessments and stay of such sale may be made until 6 months after service ends, if ability to pay is materially impaired by his service.

Extending Time to Pay—A service man during the period of his military service may have extention of time to pay on certain types of contracts until 6 months after his service period has expired.

Mortgages, Trust Deeds, Chattel Mortgages, Etc.—Unless an agreement to that effect has been executed by a person in the military service or a person ordered to report for induction or service, no sale by foreclosure, or seizure of property for nonpayment of any sum due under the terms of a mortgage, trust deed, or other security in the nature of a mortgage on real or personal property, or for any other breach of the terms thereof, whether under a power of sale or upon cognovit judgment shall be valid if made during the period of military service or within three months thereafter unless upon an order previously granted by the court. (50 USC App. 532 (3)).

Execution of judgments may be suspended if in the discretion of the court his ability to pay

is impaired by his military service. A divorce decree may be modified if upon application, but in no manner may the enlistment discharge the obligation under a separation agreement or for that of support of wife or child.

Statutes of Limitation are suspended under Ohio law, being Senate Bill 283, dated June 11, 1943, during the period of service.

In pending actions, it is necessary to file an affidavit as to military service of the defendant before taking a final decree. Filing of a false affidavit is a misdemeanor. The Court may require bond if it is not known if the person is in military service.

Ordinarily attorneys do not draw compensation for services in representing a defendant who is in military service.

No judgment may be entered by default unless the affidavit shows that the defendant is not in military service, unless the plaintiff obtains an order of the court directing that said judgment be entered.

It has been held in numerous cases that the failure to file the proper affidavit renders the judgment voidable and not void.

If, during a person's period of military service, or within thirty days thereafter, any judgment is rendered against him and it appears that he was prejudiced by reason of his military service from making his defense thereto, upon application made either by him or his legal representative, within ninety days after the termination of his service, the judgment may be opened by the court which rendered it, in order to enable such person or his legal representative to put in a defense, provided, of course, it is made to appear that he has meritorious or legal defense. The rights or titles acquired by **bona fide purchasers** for value under a judgment so rendered are not impaired by the setting aside or reversing of the judgment.

It is emphasized, however, that this act is entirely permissive, and without any formal administration. Therefore, it is necessary to make specific application under its provisions to receive protection. The law does not function automatically upon entrance of a man into service, but application can be filed after the man enters the service through his post legal officer or other legal counsel.

Industrial Health Congress

Safeguards for the health of workers will be emphasized at the eleventh annual Congress on Industrial Health which will be held in Atlanta's Biltmore Hotel, February 26-27. This event will be sponsored by the A. M. A. Council on Industrial Health, the Medical Association of Georgia, the Fulton County Medical Society of Atlanta and the DeKalb County Medical Society of Decatur, Ga.

Second District Holds Annual Meeting in Dayton

Dr. B. M. Hogle, Troy, was named president of the Second District of the Ohio State Medical Association at the annual meeting held in Dayton, October 18. He succeeds Dr. R. Dean Dooley, of Dayton.

Elected secretary and treasurer, respectively, were Dr. F. W. Anzinger, Springfield, and Dr. W. H. Hanning, Dayton. Dr. M. D. Prugh, Dayton, is the Councilor for the Second District.

During the afternoon scientific program, Dr. Alan C. Barnes, chairman of the Department of Obstetrics and Gynecology, Ohio State University College of Medicine, spoke on "The Use of Radioactive Cobalt in Treatment of Cancer of the Cervix."

A panel discussion was held on the subject, "The Use of Radioactive Isotopes in Medicine," with the following participants: Dr. F. L. Shively, Jr., chairman; Dr. D. C. Caudill, Dr. W. H. Fries, Dr. G. A. Nicoll and R. E. Zipf. Program chairman was Dr. Harold H. M. James. Special equipment in the use of isotopes was furnished by the Monsanto Chemical Company's Mound Laboratory.

Speaker at the banquet was Hon. Clarence J. Brown, Blanchester, representative from the Seventh U. S. Congressional District.

Surgeon General Puts "Go Slow" Sign On Mass Blood Typing

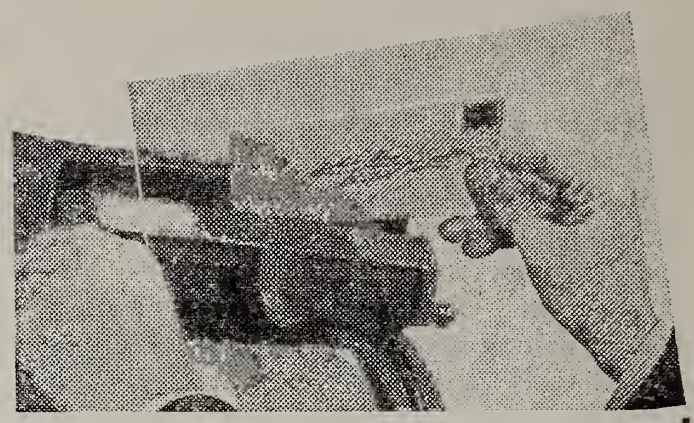
Dr. Leonard A. Scheele, Surgeon General of the U. S. Public Health Service, issued a warning against a hasty nationwide blood typing program, in an address before the Association of State and Territorial Health Officers.

Such a program might be advisable later, he said, but for the present "the best thinking of governmental agencies and professional societies . . . is that any state or local programs for mass blood-typing should be in conformity with a National Civil Defense program, the American Red Cross, American Medical Association, American Association of Blood Banks and American Hospital Association. Emphasis should be placed on typing people who can and will give blood, either in advance for storage in blood banks or for use at the time of an emergency."

He further said that the immediate need is to identify in advance type O donors in the 18 to 60 year old group. He cautioned that mass blood-typing campaigns would place severe demands on manpower and supplies of typing serum, and that errors might be expected from hastily trained personnel.

The Surgeon General's precautionary recommendations ran counter to a proposal of the Chronic Disease Division of the U. S. Public Health Service which shortly before had recommended a national mass-typing program.

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Doctors and the War . . .

Classification of Physician Registrants About Completed . . . Some Ordered Up for Physical Examinations . . . Role of Local Committees Emphasized

WHEN some of the physicians who registered with Selective Service on Oct. 16 will be ordered to active duty was uncertain as this issue of *The Journal* went to press.

However, the classification of most of the registrants has been completed by the local Selective Service Boards, the deadline having been November 15.

All physicians who registered on Oct. 16 and who are in the first priority group (those with 90 days of active duty or less) were scheduled for physical examinations on Friday, December 1.

This included all such registrants, regardless of classification. However, it does not mean that those classified as essential or who have been deferred by their local boards will be inducted at this time.

The physical examinations were made at examining centers in Canton, Cincinnati, Cleveland, Columbus, Toledo and Portsmouth.

The date for physical examination of registrants in the second priority group (those with more than 90 days but less than 21 months of active service) has not been announced.

LOCAL COMMITTEE FUNCTIONS

It is presumed that all Selective Service Boards have followed the directive of the Ohio Selective Service Office, Columbus, and have conferred with Local Medical Advisory Committees as to how registrants should be classified.

Advisory committees have been set up in each county by the County Medical Society. Of course, each board will make the final decision, but is expected to give very serious consideration to the advice given by the advisory committee.

CAN REVISE CLASSIFICATIONS

Under Selective Service regulations, a board may change the classification of a physician registrant at any time up to the time he is sent notice to report for induction.

Any physician who is commissioned in the medical corps of one of the components of the armed forces prior to the time he is sent a notice to report for induction will not be subject to induction. Such physician will be under the jurisdiction of the armed force component which commissioned him and will be subject to call as a reserve officer.

REGARDING RESERVE OFFICERS

Recently Secretary of Defense Marshall issued an "orderly procedure" directive regarding calls issued to reserve officers. This will give reserve officers advanced warning and more time to get ready before reporting for duty. Also, the directive provides that reserve officers now on duty shall be relieved from active service just as soon as suitable replacements are provided by Selective Service or can be secured from among newly commissioned medical officers.

The Army and Navy are continuing to call some medical reserve officers who have had active service, primarily to fill specialized categories. The Army has followed the policy of conferring with and obtaining clearance from the State Medical Advisory Committee before ordering its medical reserve officers to active duty. The Navy has not done so but it may adopt the same policy in the near future.

All physicians, especially reserve officers and others within the age groups subject to military service, will be interested to know that Dr. Richard L. Meiling, former Columbus physician, now director of Medical Services, Department of Defense, is making an effort to have the armed

Return Questionnaire Sent To You, Immediately

By this time every physician in Ohio should have received the Biographical and Professional Questionnaire issued by the Military Advisory Committee of the Ohio State Medical Association.

The purpose of this questionnaire is to secure vital information on all physicians in the state which can be taken into consideration in making a decision on what medical and health personnel must be retained in any community to meet the health needs of the community.

A fair decision on how many physicians can be spared from an area for military service and how many physicians must be retained in the area for civilian needs cannot be made unless the committee has an over-all picture of the present medical personnel of the community.

For this reason, every physician should fill out and return the questionnaire immediately.

services adopt a 3.5 medical officer ratio instead of the traditional 6 or 6.5 ratio. Obviously, fewer physicians would have to be taken from civilian practice if Dr. Meiling's recommendation is adopted.

INTERNS AND RESIDENTS

Interns who do not hold a reserve commission are being advised to secure one promptly in order to avoid difficulties with their Selective Service Boards. If commissioned they will not be called to active duty until completion of their internship.

It is reported that the Navy and Air Force are about to discontinue granting commissions to physicians who registered on Oct. 16 in order to permit the Army to meet its needs for medical officers from physicians of that group.

Physicians inducted will not receive the extra $100.00 per month pay even though they are commissioned after induction, the Department of Defense has ruled. Whether physicians who applied for a commission before induction but does not receive the commission until after induction, will get the extra $100.00 per month pay is still under debate in Washington.

Physicians now eligible for the draft who do not pass their physical examinations for reserve commissions will not be inducted later, if present Selective Service regulations are followed.

NEEDS OF HOSPITALS AND SCHOOLS

Local advisory boards are being cautioned to give very serious study to the needs of hospitals, medical schools and health departments.

Hospitals having residents who are essential; medical schools with essential teachers; and health departments with personnel essential to public health activities should contact local advisory committees, if they have not done so, and request that these men be considered for essential classification. As already stated, local Selective Service Boards can revise the classification of any registrant up to the time he is ordered up for induction. Also, the evidence submitted to the advisory committee will be important in requesting that certain reserve officers now serving in hospitals, medical schools and public health departments not be called to active duty until suitable replacements are available.

In many instances residents in their final year are being classified as essential until completion of their training. A formula regarding other residents may be worked out soon.

OUT-OF-STATE REGISTRANTS

Institutions and agencies having essential medical personnel which may be under the jurisdiction of a Selective Service Board in another county or another state should initiate their requests that such personnel be classified as essential with the Local Advisory Committee. That committee will then send its recommendations to the State chairman, Dr. Robert Conard, in care of the Columbus Office of the Ohio State Medical Association, who will forward the proper information to the local Selective Service Boards involved.

Former medical officers who are in doubt about whether or not their commissions are still in force will find the answer or suggestions on how to find the answer in the following statement just issued by the Council on Emergency Medical Service of the American Medical Association:

IS YOUR COMMISSION IN FORCE?

Many former medical officers have been concerned as to whether or not their commissions are still in force.

The following statements from the offices of the Surgeons General of the Army, Navy and Air Force and released by the Council on National Emergency Medical Service of the American Medical Association may help them decide that question.

STATUS OF FORMER ARMY MEDICAL OFFICERS

The key to whether a person, once commissioned, now holds a reserve commission lies in his letter of appointment. If the letter states that the apopintment was made under Section 37, National Defense Act, as amended; sets forth the grade, serial number and effective date, and states that "by direction of the President you are appointed in the Officer's Reserve Corps," he holds a reserve commission and it is still effective, unless notice of termination has been received from the Adjutant General.

Some of the older letters of appointment do not mention "Section 37 . . ." or "Officers' Reserve Corps." However, they do mention that the appointment is in the Reserve, in connection with the person's name, rank and corps (e.g., John Smith, 1st Lt. Med. Res.). Holders of such letters of appointment also hold a reserve commission, and it is still effective unless officially terminated.

Appointments in the Officers' Reserve Corps are for five years, subject to renewal. During the war all reserve commissions were automatically extended for the duration of the emergency plus six months. Since no official declaration has been made ending the emergency, such commissions are still in force, with the exception of those which have been terminated through resignation by the individual and acceptance by the government or which have been terminated for cause or the convenience of the government.

During World War II many persons were commissioned directly in the Army of the United States (AUS). These commissions do not constitute appointment in the Officers' Reserve

Corps. AUS commissions authorized during the period of World War II, under the provisions of Section 37, National Defense Act, as amended, are valid and will remain in force for the duration of the war and six months thereafter. All other AUS commissions were terminated by Public Law 239 of the Eightieth Congress.

If the letter of appointment or other pertinent papers have been lost and the person is still uncertain of his reserve status, he should write directly to the Adjutant General of the Army, Attention: Reserve Branch, Washington 25, D. C. The letter should contain a direct request as to whether the person holds a reserve commission and, if so, whether the commission is in force at this time. The letter should contain the writer's Army serial number.

Any statement to a person concerning his reserve status or nonreserve status which comes from any source other than the Adjutant General is not official.

STATUS OF FORMER NAVY MEDICAL OFFICERS

Medical officers of the Navy who served as reserve medical officers on active duty during World War II and have since returned to an inactive status are, in the majority of cases, still commissioned as reserve medical officers of the Navy. When these officers were released to inactive status from active duty, it was necessary that the individual take positive action to resign his commission in order to change his status from that of reserve medical officer to a civilian. A release to inactive duty did not automatically cancel the reserve commission which the officer had been issued prior to or at the time he went on active duty.

Physicians and dentists may have resigned their commission after their release to inactive duty, but this resignation was necessary as an individual action on the part of each person, who must have submitted his resignation of commission to the Secretary of the Navy or to other proper authority. Those physicians who are still doubtful as to their present status may obtain clarification by addressing an inquiry to the Surgeon General, Bureau of Medicine and Surgery, Navy Department, Washington 25, D.C.

STATUS OF FORMER AIR FORCE OFFICERS

Those physicians who served with the Army Air Forces prior to the designation of the Air Force as a separate military department served as Army medical officers, and the above statements concerning AUS and Army Reserve commissions are applicable to them. Those with reserve commissions still hold these commissions in the Army unless they have personally applied for transfer to the Air Force Reserve and have received notification that such a transfer has been effected.

Dr. Beck Conducts Resuscitation Course in Cleveland

A practical course for resuscitation of patients who die in the operating room is being offered by Dr. Claude S. Beck under sponsorship of the Cleveland Heart Society. The course, available to surgeons and anesthetists, is being offered once each month through March.

The first course was held in November. Dates for the remaining courses are as follows: December 14-16; January 25-27; February 15-17; and March 15-17.

Program for each of the courses is as follows:

First Day, 9:00 a. m. to 12:30 p. m.—(Surgical Laboratory, Western Reserve University School of Medicine) General presentation of subject and demonstration on dogs (Dr. Beck, Dr. Robert W. Hosler, Dr. Richard Hahn, Kenneth Wolfe and Mary Ellen Kaiser, R. N.)

2 to 4 p. m.—(Institute of Pathology) Transthoracic and subdiaphragmatic approach to the heart—cadaver demonstration (Dr. Alan Moritz and Dr. Hosler).

4 to 5 p. m.—(Institute of Pathology) the Sterile Package (Dr. Hosler).

Second Day, 9 a. m. to 12 m.—Lecture, "Factors in Cardiorespiratory Failure"; danger signals; intubation of the trachea. Lecture to be given on alternate basis by Dr. B. B. Sankey at St. Luke's Hospital and Dr. Donald E. Hale, Cleveland Clinic Hospital.

1:30 to 3 p. m.—Laboratory Demonstration; effect of procaine and adrenalin on the heart; effect of dislocation of the heart; methods of massage of the heart (Dr. Beck and Dr. Hosler).

3 to 5 p. m.—Lecture; physiological aspects of resuscitation; drugs; maintenance of circulation after restoration of heart beat (Dr. Herman Hellerstein).

Third Day, 9 a. m. to 12 m.—Practical exercise on dogs; demonstration of oscillograph and electronic stethoscope (Dr. James H. Rand, III).

12 m. to 1:30 p. m.—Program of action in the operating room; drill (Dr. Beck).

Those interested in enrolling are requested to contact Jerry H. Bruner, executive secretary, Cleveland Heart Society, 613 Public Square Building, Cleveland 13.

Dr. John J. Douglas, Canton, discussed the subject, "Radiological Diagnosis of Congenital Heart Disease," at the annual Rochester Medical School Alumni meeting in Rochester, N. Y.

Dr. Edmond J. Booth, Coshocton, spoke on the subject, "Genito-Urinary Diseases," at a meeting of District Six, Ohio State Nurses' Association.

Admission to Mental Institutions . . .

Legal Counsel Clarifies for Physicians' Benefit Changes in the Law And Procedures for Having Mentally Ill Placed in State Institutions

THE terms "mental illness," "mentally ill," "mental disease," and "mentally deficient" have been defined in Ohio as "an illness which so lessens the capacity of the person to use self control, judgment, and discretion in the conduct of his affairs and social relationships as to make it necessary or advisable for him to be given treatment, care, supervision, guidance, or control."

The above definition also includes the terms "lunacy," "unsoundness of mind" and "cases in which such lessening of capacity for control is caused by excessive addiction to narcotics, stimulants, or sedatives as to make it necessary for him to be under treatment, care, supervision, guidance, or control."

With this legal definition of mental illness of such broad scope, almost any physician may expect to have under his care, sooner or later, a person whose illness falls within the meaning of the definition. Many neuroses, whether they result from physical illness or otherwise, can be expected to cause sufficient emotional disturbance that a patient may enter one of the above categories, if adequate treatment is not achieved.

Facilities for outpatient treatment have as yet come no wise near satisfying the demand. Therefore, a problem arises for the physician and for the relatives and friends of a mentally ill patient, as to where treatment can be provided, how quickly it can be provided, and what procedure must be followed under the laws of the State to place the patient in the proper custody and under suitable care.

FOUR TYPES OF METHODS

Under the laws of Ohio, procedures for handling these cases are fairly well defined and are designed as far as possible to answer the problems in each case. The immediate source of information on these matters is the Probate Court of the county in which the patient resides. However, it is of material aid to interested parties, and especially to physicians, that they have a general knowledge of what the necessary procedures are. There are four general types of methods by which a patient can be handled.

A. Formal Commitment or Placement.

Under Section 1890-20 of the General Code of Ohio, the next of kin of the patient, or an interested person residing in the county may go before the Probate Court of that county and file an affidavit or sworn statement giving the following information:

(1) The name and residence of the patient.

(2) His belief that the patient is mentally ill or in need of specialized observation or treatment.

(3) A statement as to whether or not the patient is dangerous to himself or others, and would be dangerous to the community by reason of the supposed mental illness, if he were to remain at large.

(4) A statement as to any prior commitment to a mental or penal institution in this state or elsewhere.

(5) The name and address of the personal physician or physicians known to the patient, if any.

After this affidavit is filed the Probate Court issues a warrant for the detention of the patient and may have him held in the county jail or otherwise as the court may direct, until a hearing may be had on his case. The court notifies the relatives or interested parties of the date of the hearing and allows the patient to select such persons as he may wish to attend.

If the patient is incapable of making a selection, his attorney, relative or a friend may be notified. If no one is available, the court is required to appoint a suitable person to act as Guardian *ad litem* for the patient. The court will appoint a physician to be the official examiner of the patient. The physician must be registered in the State with at least three years of experience in the practice of medicine.

COURT CONDUCTS INQUIRY

When these persons have been served with notices and the hearing date has arrived, the

Editor's Note: The accompanying article, prepared by Mr. Wesley L. Neville, legal counsel, Support Bureau, State Division of Mental Hygiene, summarizes the present Ohio laws pertaining to admission to mental institutions and clarifies admission procedures.

The article was written with the intent of making it helpful to physicians. It should be read carefully by all readers of *The Journal*, then clipped and filed for ready reference.

court conducts an inquiry, without a jury, and examines the witnesses who have appeared and such others whom he may wish to hear on the subject. A report of the examination of the patient is made by the physician appointed by the court. This report becomes a part of the records of the case. If, at the end of the hearing, the court is certain that a patient is mentally ill, he has several alternatives upon which he may proceed at his discretion.

1. He may order the patient to be placed in a Receiving Hospital for observation or treatment or both.
2. He may commit him to the proper state hospital for the mentally ill for treatment.
3. If he finds that the patient has been convicted of a felony, and finds him to be mentally ill, mentally deficient, psychopathic, or insane, he may order him committed to such hospital as the Department of Public Welfare may designate for such cases.
4. If the patient is a veteran of any war, military occupation, or expedition, and is eligible for treatment in a United States veterans' hospital, the court may communicate with the official in charge of the veterans' hospital, and upon receipt of a certification from that official the patient may be committed to that hospital.
5. He may order the patient placed in a private hospital, (one of the institutions recommended and approved by the Division of Mental Hygiene) at his own expense.
6. He may release the patient to the custody of a relative, friend, or another suitable person, whom the court deems proper.
7. He may commit him to a county home or to the place provided by the county commissioner, if any.
8. He may discharge him.

This procedure is most used in cases where the patient is difficult to handle, refuses to cooperate in treatment, and refuses to voluntarily enter an institution for treatment. On the other hand, some objections to this method are: The time consumed; the fact that the proceedings become a part of the records in the Probate Court; and the fact that in many cases the condition of the patient does not warrant such a formalized procedure. It is because of these factors that many people are reluctant to use the formal commitment. (G. C. Sections 1890-23, 24, 25, 27.)

All of the forms necessary to institute the foregoing method are obtainable at the County Probate Court.

B. Voluntary Admission.

Physicians will have many cases where the patient is aware, or may be made aware, of his condition and the need for proper treatment. Thus, the physician is able to obtain his cooperation in voluntarily entering a mental institution. This is a relatively simple procedure, since it involves only the written application of the patient himself, together with a certificate from a reputable physician on forms provided by the Division of Mental Hygiene.

There is nothing mandatory about the voluntary admission procedure since the patient goes of his own free will and is accepted with only the proviso that he remain in the hospital for ten days. At the end of this time he may make a written request for dismissal.

If the superintendent and medical staff feel that he should not be released and the patient refuses to continue treatment, he cannot be retained unless the superintendent initiates formal commitment proceedings as mentioned in the preceding section.

Voluntary admission can only be made at the hospital serving the district in which the patient resides, and the superintendent may accept or refuse any voluntary patient.

This procedure may also be used by parent or Guardian on behalf of a minor or on behalf of an adult incompetent, respectively. The primary value of this method lies not only in the fact that a patient may obtain his own admission, but also that many mental illnesses may be forestalled or cured in the same manner as a physical illness could be controlled or cured by early hospitalization in a general hospital. Besides this, there is no likelihood of the publicity possibly resulting from a court commitment. (Section 1890-52, G. C.)

The forms necessary for voluntary admission may be obtained from the county Probate Court or from the Superintendent of a State Hospital. It is suggested that a number of such forms be made available to the Secretaries of the County Medical Societies or to County Health Centers where they would be readily obtainable by physicians who were recommending this course of treatment for their patients.

C. Emergency Admission.

Cases arise from time to time where a mentally ill person may be violent and dangerous to himself or members of the community in which he lives. In such cases a member of the family, a police official, or a member of the Board of Health of the community may provide for the detention of such person without a warrant and may take him at once to a Receiving Hospital.

These Receiving Hospitals are of a compara-

tively recent origin and it is proposed that they be established in each district now served by a state hospital. Receiving hospitals are established to provide preliminary and emergency care and for observation and treatment, especially of those cases where the condition is mild or incipient only and is expected to be of comparatively short duration. Receiving hospital cases which do not improve in a relatively short time are transferred to state hospitals. This method of handling cases such as the above is expected to remove a considerable load from the present state hospitals.

The law provides that if no such Receiving Hospital is immediately available, the person may be placed in the city or county jail until further disposition can be made. When he has been placed in jail, the arresting officer or the person in charge of the jail is required to file an affidavit in the Probate Court on the next succeeding law day. Persons who are held in jail are required to have an immediate examination by a physician and medical and nursing care will be at the expense of the county or city having jurisdiction of the jail.

Under the terms of this provision such a patient may be held for a period of five days in either the receiving hospital or the county jail. His period of detention in a city or village jail may not exceed twelve hours. At the end of the five day period, the superintendent of the receiving hospital must begin proceedings for formal commitment according to the statute.

Persons acting in good faith under the terms of this statute are specifically protected from the possibility of a law suit by the patient or by persons acting for him by reason of his arrest and restraint. The intention of this statute is to provide adequate and immediate protection, both for the patient and the community, when the patient indicates homicidal or suicidal tendencies or other violent dispositions. **It is a temporary and emergency measure only** and as noted above, the formal legal procedures for proper detention must be followed within a short period of time. (Sec. 1890-26 G. C.)

D. Admission Without Formal Commitment.

In order to satisfy a need that was not adequately met by the foregoing procedures, a new means of admission to mental hospitals was provided by the General Assembly on June 24, 1949. Under this law, a patient may be placed in the appropriate hospital or other institution designated by the Division of Mental Hygiene without immediate court procedure. The period of the admission in any case cannot exceed six months. Under this form of admission, a written request must be made by a member of the patient's family, a friend, any person with whom the patient lives, or by any law enforcement officer, who has taken the patient into custody. Certain other authorized persons are the chief officers or superintendents of a hospital, a charitable institution, or a licensed social agency. If the patient is a veteran and is otherwise eligible, arrangements may be made to enter him in the appropriate veterans' hospital.

The person making such written request must have reasonable cause to believe that the patient is mentally ill. **The patient must be examined by at least two physicians registered in Ohio and having had at least three years in the practice of medicine.** These physicians may not be members on the staff of the mental institution or hospital to which the patient is to be sent, nor be financially interested in this institution.

After the physicians have examined the patient, they must make a full medical report. They must certify that they have examined him and that they believe he is mentally ill and requires hospitalization. This report and certification together with the written application or request are sent to the superintendent of the hospital in the district in which the patient resides. The determination of whether or not he is to be admitted is at the discretion of the superintendent.

In the use of this method it is important to note that the patient, while he is not precisely a voluntary case, may not be taken to the hospital against his will or by the use of force. If the patient is entirely unwilling to go and is not susceptible to proper persuasion, the only method available will be that of court commitment. To do otherwise would result in the deprivation of his liberty without due process of law, a right guaranteed to all persons under the Constitution.

This course of action requires no court procedure and there is no necessity for publicity of any kind. It provides a speedy method of admission in the event of emergencies, particularly where the patient is in such condition that he may be dangerous to himself or to others, as in cases of suicidal or homicidal tendencies, hallucinations and delusions.

In many cases of mental illness, just as in many cases of physical illness, the patient is in no condition to determine for himself whether or not he should be institutionalized. A few examples of this are cases of coma, catatonic states, and so forth. On the other hand, he will not make any overt objection to his admission to the hospital. In such cases, as in the case of one who is extremely ill physically, the speedy admission will be to the benefit of the patient.

In order that the legal rights of a patient may be further protected under this section, the law requires that if, at any time after his

admission, he makes a written request to the superintendent for his discharge, the request shall be granted unless the superintendent feels that the patient's condition warrants his retention in the hospital.

In that case, within five days after the written request has been made, the superintendent must file an affidavit in the Probate Court of the county in which the hospital is located, or the county from whence the patient came. With the affidavit he must file the written report and certification filed at the time of the patient's admission. When this has been done by the superintendent, the regular procedure for court commitment will be followed and the patient will be retained in the hospital until judicial determination of his mental condition has been made.

If the patient has not requested his discharge at the end of 120 days from the date of his admission, and the superintendent does not feel that he should be discharged, the superintendent must file an affidavit, as mentioned in the preceding paragraph, to start poceedings in the Probate Court for an adjudication of the patient's condition.

The forms for this procedure may be obtained at the county Probate Court or from the superintendent of any State hospital. As in the case of voluntary admission, forms should also be made available to the Secretaries of County Medical Societies and to County Health Centers. (Sec. 1890-111 to 111-G G.C.)

THE MENTALLY DEFICIENT

The law of this State provides that with certain exceptions the State of Ohio shall have the care, custody, control, and treatment of persons adjudged to be feebleminded and admitted to any institution for the feebleminded in this State.

The term "mentally deficient" or "feebleminded" as meant by the law refers to any person whose "intellectual development has been retarded from birth or from an early age and whose intellectual and social capacity is below normal for his chronological age to such an extent that he lacks sufficient control, judgment, and discretion to manage himself and his affairs and who by reason of such deficiency, for his own welfare or the welfare of others of the community requires supervision, guidance, care, or control." (Sec. 1890-97 G. C.)

With one exception, the provisions for the formal commitment of a feebleminded person are the same as those pertaining to a person who is mentally ill. The exception is that the affidavit to be filed in the Probate Court shall contain the allegation that the person is "feebleminded and in need of specialized care and treatment."

There have been cases where an affidavit has been filed alleging that a patient is mentally ill, yet upon examination by the court he is found to be without psychosis, but suffering from a mental deficiency which leads to his apparently anti-social conduct. In such cases the court is at liberty to commit him to a hospital for the feebleminded without the filing of a new affidavit.

The provisions regarding discharge, release, or trial visit and return, and the control and custody of a feebleminded patient are the same as those pertaining to mentally ill patients. Feebleminded persons of any age, whether they be public charges or not, may be admitted to hospitals for the feebleminded, if in the judgment of the Division of Mental Hygiene, they are proper subjects for the care, treatment, and discipline provided in such hospitals.

V. A. Restricts Use of Cortisone On Out-Patient Basis

Inasmuch as cortisone is now available for dispensing by retail pharmacies on prescription, physicians will be interested in a restrictive policy recently announced by the Veterans Administration.

The announcement directed to pharmacists states that effective November 15, 1950, prescriptions for cortisone should not be accepted by participating pharmacies for compounding at V. A. expense. This restriction will apply also to all dosage forms of the product that might become available in the future.

Since it appears probable that ACTH might also be made available in the not too distant future, the same restrictions will apply, according to the statement.

The announcement goes on to say that V. A. fee basis physicians are being advised of this restriction, and that limited quanities of these items for out-patient use will be supplied from the Regional Offices of the V. A. on a highly selective basis.

In an explanation of its announcement, V. A. stated that professional personnel in its office feel that there is much to learn concerning the drug's potentialities when used on a long term basis and that its use should be carefully controled. In addition budget estimates for V. A. drug expenditures for the present fiscal year were established prior to the availability of cortisone and since it is relatively expensive, adequate funds for any indiscriminate use would not be available.

Dr. Frank P. Corrigan, Cleveland, was the subject of a feature article in the *Cleveland News*. He is devoting his time as a member of the United States mission to the United Nations.

Miners' Program Expanded . . .

U. M. W. A. Fund Benefits Now Extended to Totally Disabled Members And Dependents, Surviving Older Widows and Children, Certain Others

ESTABLISHMENT of a new program of benefits by the United Mine Workers of America Bituminous Welfare and Retirement Fund, in addition to the existing program for death benefits, pensions and hospital and medical service, has been announced.

The new program includes benefits for totally disabled eligible miners and their dependents; maintenance aid for older widows and dependent children of deceased miners; and extension of medical and hospital services to widows and adult dependents of miners.

The trustees of the Fund in making the announcement emphasized that the additional benefits now to be provided are not in any sense a restoration of the former disability benefits. On the contrary, they said, it is an entirely new service with different eligibility requirements and benefits.

Payments by the Welfare and Retirement Fund were temporarily suspended in September, 1949. The hospitalization and medical care phases of the program were resumed on July 1, 1950. It has now been announced that the disability benefits service of the former program has been discontinued permanently.

Rehabilitation for totally disabled miners, with cash benefits for the miner and his family while he is undergoing treatment, is a major service of the new program. There also will be maintenance grants made available to the miner and his family in cases where it is determined that a U. M. W. A. member is totally and permanently disabled.

Maintenance cash benefits also were authorized for dependent children of deceased miners and for widows who are 50 years of age or older. The schedule of such maintenance aid calls for $40 a month for an eligible child living with a widowed mother, and for $10 for each additional dependent child. This is for children under 18 years of age or those incapacitated if over 18. Widows who are 50 or more and who have no dependent children are to receive $30 a month.

MEDICAL CARE

The present hospital and medical service for U. M. W. A. members, their wives and children under 18, is extended to include widows and dependent children of deceased miners and also to adult dependents of living miners, but the latter are limited to 60 days of hospitalization in any twelve-month period.

Officials of the Fund stated that the new benefits are considered the maximum the Fund can provide under sound administration to meet the most urgent needs in the mining areas.

To receive rehabilitation benefits or maintenance aid for disabled miners, an applicant must be presently totally disabled from any occupation, and fall within one of the following categories:

1. Have attained the age of 60 at date of application and have been totally disabled for one year preceding date of application;
2. Have attained the age of 55 and have been totally disabled from any occupation for two years preceding the date of application;
3. Have attained the age of 50 and have been totally disabled from any occupation for three years;
4. Have attained the age of 45 and have been totally disabled for four years;
5. Be under 45 years of age and have been totally disabled from any occupation for five years.

REHABILITATION BENEFITS

The amount of rehabilitation benefits for miners undergoing treatments specified by the Medical Service of the Fund, is $30 a month with an additional $10 for a wife, an additional $10 for each child under 18, and an additional $10 for each incapacitated child over 18 who is dependent on the miner and living in his household. These benefits are less any regular income received from any source.

For those eligible miners whom the Medical Service certifies to be totally and permanently disabled and not amenable to further rehabilitation measures, there is provided a maintenance aid with the same benefit amounts for the miner and his wife and children.

Applicants who are considered eligible for rehabilitation by the Fund, after they have met all non-medical requirements, will be referred to their Area Medical Administrator for examination by physicians with whom arrangements have been made by the Medical Service of the Fund. Officers announced that it is the intent of the service to rehabilitate and restore to useful occupational life every injured or ill miner where it is possible to do so.

SURVIVORS

Widows who were living with or were being supported by deceased miners at the time of the miners' deaths shall be eligible for maintenance aid in the following amounts, less regular in-

come received from any source and under the following requirements:

1. Widows 50 years of age and over (a) with no children, $30 per month; (b) with one child under 18, or over 18 if incapacitated, dependent upon and living with her, $40 per month; (c) for each additional child, $10 per month.

2. Widows under 50 years of age (a) with one child under 18, or over 18 if incapacitated, dependent upon and living with her, $40 per month; (b) for each additional child, $10.

Payments to widows terminate upon remarriage of the beneficiary. No provisions are made for widows under 50 years of age who do not have dependent children.

MEDICAL SERVICE

Benefits under the Hospital and Medical Service of the Fund are extended to include:

1. Widows of deceased miners;

2. Unmarried relatives of deceased miners who stand in the relation of mother to such miners' orphaned children under 18 or incapacitated dependent children over 18;

3. Dependent children under 18 of deceased miners.

Benefits for persons enumerated in foregoing paragraphs 1 and 2 terminate upon marriage or remarriage.

The following persons who are disabled by injury or disease are eligible for hospital and medical care benefits not to exceed 60 days hospitalization in any twelve-month period:

1. Relatives of miners who are dependent upon and are living with them in their household and have been dependent upon and living with them continuously for six months next preceding their applications for benefits and have no regular source of income.

2. Children over 18 of deceased miners who are dependent upon and living with their widowed mothers or any person who stands in relation of mother to such miners' orphaned children in their household and have been dependent upon and living with them for six months next preceding their application for benefits and have no regular source of income (such benefits to terminate upon marriage or remarriage).

The previously-established Hospitalization and Medical Care Program of the Fund was explained in the August issue of *The Journal*. Dr. Leslie A. Falk, Pittsburgh, Pa., is area medical administrator.

Dr. H. M. Clodfelter, Columbus, was principal speaker at the annual dinner of the Perry County Red Cross in New Lexington. Dr. Clodfelter is vice-chairman of the Medical Advisory Committee of the Columbus Regional Blood Center.

State Health Officers Take Stand Against Socialized Medicine

Dr. John D. Porterfield, director of the Ohio Department of Health, was elected secretary-treasurer of the Association of State and Territorial Health Officers at its meeting in Washington, D. C., October 23-27. Dr. Roy L. Cleere, executive director of the Colorado Department of Public Health, was elected president.

Among actions taken at the meeting were the following:

The Association urged amendment to the law to prevent "incorporation into or on food of chemical or other new ingredients before they have been reviewed and approved by the Food and Drug Administration."

It criticized Congress and the Federal government for reducing grant-in-aid-programs, and directed special attention to the 50 per cent reduction in hospital authorization funds, "which seriously and drastically disrupts the programs for long-range planning by communities and states."

It urged support for legislation providing Federal financial assistance to state health departments and developing and maintaining local public health units, "organized to provide basic full-time public health services in all areas of the nation."

It called on the National Security Resources Board to make available the manual on health and medical aspects of civil defense "without further delay."

It reaffirmed its opposition to national compulsory health insurance and renewed its demand for creation of a Federal department of health with cabinet status under direction of a career physician in public health.

National health insurance is unnecessary, the resolution says, because voluntary health and hospitalization plans are "rapidly and progressively developing to meet the apparent needs of the people." The resolution notes the progress in preventive medicine, protective sanitation against evironmental hazards and proper public health information, and says a major factor in this progress has been the work of organized public health service with qualified personnel. At the outset the resolution states that ". . . it is generally recognized that the people of the United States now enjoy the highest standards of health of any country in the world."

The opening fall meeting of the Fort Steuben Academy of Medicine was held on Oct. 10 at the Fort Steuben Hotel in Steubenville. Dr. Hans May, of Philadelphia, discussed phases of plastic surgery. The meeting inaugurated the fifth annual program of the Academy which consists of doctors of the Steubenville area.

Industrial Commission . . .

$4,607,391 Disbursed by Ohio Agency for Medical Service in 1949, Report of Actuarial Section Shows; Claims Filed Totaled 275,471

THE Industrial Commission of Ohio paid out $4,607,391 for medical services to injured Ohio workmen during 1949, according to a report issued by the Commission. Included in the amount is a relatively small sum for dental services.

Other expenditures during the year, exclusive of compensation payments, included: $3,512,507 for hospital care and nursing; $152,539 for funeral expenses, and $126,369 for miscellaneous costs. With disbursements for medical services added, the total is $8,398,806.

These amounts include payments covering treatment of injured private and public employees, as well as similar costs for occupational disease claims.

Comparative figures for 1948 were as follows: $4,515,016, medical services; $3,085,151 for hospital care and nursing; $165,863, funeral expenses; $110,444, miscellaneous costs—a total of $7,876,474.

DECREASE IN CLAIMS

The number of claims filed during 1949 was 275,471, or 8½ per cent less than in 1948. The peak year in number of claims during the 38-year history of the Ohio Workmen's Compensation Fund was 1943 when the number of claims reached 331,072, 81 per cent of which were "medical-only" claims. The average number of claims filed each working day in 1949 was 1,097.

"Medical-only" claims, involving payment for physicians' services, but with no compensation to the claimant for loss of time, numbered 211,050 in 1949, or 77 per cent of all claims filed. The average amount paid out per "medical-only" claim decreased from $10.01 in 1948 to $9.48 in 1949.

BASIC RATE CHANGES

Basic rates were lowered in two classifications, raised in 304 and remained unchanged in six, according to the *Actuarial Review*.

Table 1 is a financial statement of the Ohio State Insurance Fund.

Table 2 gives 1949 disbursements that have been paid for active claims according to year of injury, and having injury dates which in some instances reach back to the beginning of the fund.

TABLE 1

OHIO STATE INSURANCE FUND

(Workmen's Compensation)

(Workmen's Compensation)

STATEMENT OF FINANCIAL CONDITION
As of December 31, 1949

ASSETS

	Private	Public	P.W.R.E.	Safety & Hygiene	Total
Cash	$ 2,548,174.82	$ 132,665.82	$ 13,777.47	$ 12,850.53	$ 2,707,468.64
Bonds	151,370,938.39	7,765,917.22	773,369.35	1,208,389.61	161,118,614.57
Premiums in Course of Collection	1,865,151.79	1,452,274.02	5,381.80	.....	3,322,807.61
Accrued Interest	848,778.04	42,060.63	3,602.62	6,214.52	900,655.81
Total Assets	$156,633,043.04	$9,392,917.69	$796,131.24	$1,227,454.66	$168,049,546.63

LIABILITIES

Reserve for Medical & Compensation Benefits	$109,608,702.00	$7,997,660.12	$105,633.67	$	$117,711,995.79
Reserve for Contingencies	18,500,000.00	387,301.07	20,500.00	.....	18,907,801.07
Reserve for Allocated Surplus Adjustment	.....	808,439.00	.....	.....	808,439.00
Unearned Premium	7,895,624.00	199,517.50	.....	.....	8,095,141.50
Fund	.....	.....	.....	1,227,454.66	1,227,454.66
Surplus	20,628.717.04	.....	669,997.57	.....	21,298,714.61
Total Liabilities	$156,633,043.04	$9,392,917.69	$796,131.24	$1,227,454.66	$168,049,546.63

TABLE 2

1949 Awards Distributed to Year of Injury Occurrence
(Accidents and Occupational Disease Combined)

Year of Accident or Disease	Compensation	Medical Hospital, Etc.	Total	Per Cent
1949	$ 3,666,573	$ 3,746,784	$ 7,413,357	25
1948	5,307,685	2,663,224	7,970,909	27
1947	3,411,245	541,522	3,952,767	13
1946	1,954,505	263,674	2,218,179	8
1945	1,526,953	147,279	1,674,232	6
1944	1,490,570	101,688	1,592,258	5
1943	1,134,566	121,090	1,255,656	4
1942	706,789	77,441	784,230	3
1941	333,494	35,247	368,741	1
1940	228,754	38,184	266,938	1
1912 - 1939	1,763,072	147,945	1,911,017	7
Total	$21,524,206	$ 7,884,078	$29,408,284	100



Constipation in the Postsurgical or Bedridden Patient

The combined effects of enforced inactivity, poor appetite and dietary restrictions frequently result in bowel sluggishness.

By adding bland "smoothage" and assuring a normal fecal consistency and volume, Metamucil gently initiates reflex peristalsis and encourages a return of normal bowel function.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

METAMUCIL® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. G. D. Searle & Co., Chicago 80, Illinois.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

REFLECTIONS ON THE NOV. 7 ELECTION

November 7, 1950, can be chalked up as a banner day for the medical profession of Ohio. In case you don't remember, that was Election Day.

Reflections on the activities which were carried on prior to November 7 and on the results at the polling places of the state on that day should give many physicians of Ohio and their wives a deep feeling of satisfaction and pride.

Physicians of Ohio and their wives are being credited by candidates and by many others who took a personal interest in the 1950 election contests with having played an outstanding role in bringing about the upheaval which swept into public office a host of candidates, who for the most part, are well qualified and who are opposed to Fair Deal socialism—national, state and local.

Of special importance was the job done by Ohio physicians and their wives, as well as other professional and business men and their wives, on behalf of Senator Robert A. Taft who was returned to his seat in the U. S. Senate by one of the largest majorities ever given to an office-seeker in Ohio.

The physicians of Ohio and their wives did nothing especially unique in the campaign which they carried on as citizens in support of Senator Taft and many other candidates who stood for honest, efficient government and for sound basic principles.

The tactics which they used were neither new nor original.

Their real achievement was that they rolled up their sleeves and went to work—in large numbers and many of them for the first time—putting to practical use proven methods and techniques. In other words, as independent, thinking citizens they engaged in practical politics.

What are some of the lessons learned during the rather hectic pre-election battles waged in all parts of the state? Following are a few which, in our opinion, are of major significance:

The overwhelming majority of Ohio voters, when the issues are clearly defined and adequate information on the qualifications of candidates is disseminated, will vote not as a class, as a mob, as stooges of political bosses or under intimidation, but as independent, thinking citizens.

Members of the medical profession, long regarded as potentially powerful in political and civic activities, actually can be a mighty political force, providing they shed their traditional reticence. Also, if enough of them will take a personal interest and will conscientiously follow through on their individual assignments.

New or unique techniques are not necessary to achieve results. Tried and true methods which have been used successfully by astute politicians and citizens' groups working in their behalf are enough. However, these methods will suffice only if accompanied by hard work and perfect follow-through on the part of those in the ranks —which was done in Ohio in 1950.

Physicians have learned that they can make a real contribution by coordinating their activities in support of qualified candidates with the activities of other groups mutually interested in electing candidates whose views on social, economic and governmental questions are sound.

Systematic long-range planning is necessary. Good field work is essential. Careful selection of key persons is vital.

The medical profession, and others whose views coincide with the views of the medical profession, dare not regard the satisfactory results in 1950 as final. A similar job must be done prior to each election—national, state or local. To maintain the active interest of physicians in political affairs, similar activities must be undertaken year after year.

Every medical society has a role to play in pre-election campaigns and should be prepared to do so. Although confronted with certain legal limitations, each medical society can, legally and properly, interview candidates and pass on to its members information relative to their qualifications and opinions on medical-health issues. It is up to the individual physician then to make use of this data as he sees fit. Moreover, it is not only the right but the duty of the medical society to pound away at its membership on the point that physicians are citizens and that citizenship carries with it certain responsibilities and obligations, one of which is participation in political affairs.

The force and influence which can be brought to bear by the individual members of the woman's auxiliary of a medical society must not be overlooked. A remarkable job during the 1950 pre-election campaign was performed by the wives of thousands of Ohio doctors.

Political activities by physicians, or anyone

else, must start at the grass roots—at least the bullets must be fired at the grass roots.

Entanglement in partisan politics can be avoided. Workers will really do the job regardless of party affiliations when medical issues or issues involving democratic principles are at stake, or inferior candidates in the running. True, socialized medicine was one of the issues debated in Ohio during the 1950 campaigns. Nevertheless, it was made a partisan issue because of the propaganda issued by one of the major political parties and because of the voting records or known beliefs of some of the candidates. That being the case, the physicians of Ohio and others who agree with their views on this question, had no choice but to take a stand and let the chips fall.

OHIO REAPS THE WHIRLWIND AS U. S. CUTS HEALTH GRANTS

Ohio will probably take a beating on hospital construction and on some of its essential public health services during the ensuing months.

Why? Primarily because Ohio has been relying too heavily on Federal Funds for these activities and now Federal grants have been cut.

The cuts announced will amount to about 12 per cent of the Ohio Department of Health's total resources. Aside from the hospital building program, other programs which will have to be curtailed due to reduction in funds, include: Tuberculosis, general health, heart disease, cancer and venereal diseases.

Two years ago spokesmen for the Ohio State Medical Association stood before committees in the State Legislature, pleading for a better financial deal from state funds for the health department. They hoisted the warning that Ohio was largely at the mercy of Uncle Sam—to the extent of about 75 cents out of each dollar spent. They expressed the fear that Ohio would surely suffer if the Federal Government decided to reduce grants-in-aid. These warnings went unheeded.

Now Ohio is behind the eight-ball.

Ohio citizens want a strong state department of health, as well as strong local health departments. In our opinion they will be willing to foot the bill. They are not going to like this turn of events, we believe.

The new General Assembly convening in January ought to take a really serious look-see at the situation. A more equitable distribution of state money among the administrative departments must be worked out. If that is done, the health department's status can be improved.

If it were not a serious matter, the observation might be made that the great State of Ohio is getting just what it deserves.

DO YOU ITEMIZE YOUR STATEMENTS?

You may not agree but in our opinion the following excerpt from a bulletin of the Illinois Medical Society hits the bull's-eye and makes a lot of sense—contains a suggestion which all physicians would do well to follow:

"Would you pay your bill at the garage if it came to you: 'Repair on 1948 car—$64.32'? You'd much rather know that $8.00 went for checking the front end alignment; $1.25 for adjusting brakes; $1.25 for switching the tires, and that parts amounted to $22.75 and the rest was labor.

"Perhaps Mrs. Jones didn't understand the charges for Junior's case of infectious mononucleosis; maybe she doesn't know what laboratory work is. Did you explain to her exactly what was wrong with Junior? Did you tell her why laboratory work had to be done? Does your bill carry the statement that you made a night call on Wednesday, June 20th? If it does, maybe she'll remember how glad she was to see you.

"Or did you send Mrs. Jones a statement for 'Services rendered'?

"Think it over. Put on Mrs. Jones's size 5½ shoes for a while and see if they pinch—just a little."

PROGRESS MADE IN FORMING STUDENT A. M. A.

It's gratifying to know that progress is being made in organizing the Student American Medical Association.

An excellent piece of education can be done once this organization is on a going basis. There certainly is need to familiarize medical students with the aims and purposes of medical societies—local, state and national—and to keep them up to date on current events and developments affecting the medical profession.

This can be done more effectively through an organization of their own than at present, although there is still a definite place for talks and discussions with them, sponsored by medical societies where the schools are located.

COLLEGE OF SURGEONS CONTINUES HOSPITAL INSPECTION

An alarm sounded by the A. M. A. to the effect that the American Hospital Association had proposed taking over the traditional standardization and approval of hospitals by the American College of Surgeons was reported in the November issue of *The Journal*. Physicians can now be reassured. At a recent meeting the regents of the College voted unanimously to continue the program.

Commenting on action of the board of regents,

The Journal of the A. M. A. points out that this action does not necessarily preclude consideration of proposals for participation of other interested agencies in this program but does make it clear that the American College of Surgeons has an undiminished interest in it and will consider no proposal which will not insure its continuation in the best interests of the public.

EWING BLISTERED FOR POKING NOSE INTO OHIO POLITICS

Dr. Ed. McCormick really blistered Oscar Ewing in a statement published in Toledo newspapers, answering Ewing's attack on Senator Taft and the A. M. A. at a Toledo union meeting which had been billed as a discussion of national health insurance—not politics or the A. M. A.

Said Dr. McCormick:

"Mr. Ewing demonstrated his usual lack of respect for facts, truth and the right of the American people to think for themselves. He completely distorted the motives, methods and results of the A. M. A. advertising program.

"Mr. Ewing apparently has lost all political restraint and all sense of intellectual decency in his frantic, frustrated efforts to play politics with the health of the American people. He now maligns not only the medical profession, but also all Americans who choose to agree with the medical profession.

"His psychotic distortions, inaccuracies and accusations are an insult to the intelligence and integrity of all Americans who believe in freedom of speech and fair play."

The council of the Toledo Academy of Medicine advised members to turn down invitations to attend the meeting as it felt "this attempt by an Administrative officer of the government to influence legislation and our Ohio elections is both improper and a misuse of public funds."

HATS OFF TO TOLEDO AND CLINTON COUNTY SOCIETIES

The Toledo Academy of Medicine and the Clinton County Medical Society are requested to step forward and take a bow.

In a recent issue of the A. M. A. Public Relations Bulletin, "The PR Doctor," a nice boost was given to the Toledo Academy on its newspaper advertising program.

An editorial in a recent issue of *The Journal of the A. M. A.* complimented the Clinton County Medical Society on the fine work which it carried on, with other local groups, in making a health survey of the county.

These are examples of things which county medical societies can do if they want to.

ALL IS NOT WELL WITH BRITISH HEALTH SCHEME

Britain's national health scheme is threatened with collapse, Socialists in the southeast London area warned Health Minister Aneurin Beven recently. A committee including doctors warned that the increase in patients and the lack of doctors mean overworked doctors, dissatisfied patients and the end of personal relations with them.

The report said that a total of 17,545 doctors received $106,398,493, which gave them individually less than half the income earned by dentists. About 13,400 pharmacists and suppliers of surgical appliances shared $81,763,380. Payments for ophthalmic services totaled $57,596,980.

Meanwhile resignation forms are going out to all general practitioners from the British medical guild with an urge that doctors resign if their pay claims are not met by the end of the year. The British Medical Association has been negotiating since January, 1948—six months after the health service started—for revision in the pay system.

Wholesale issuance of prescriptions presents another bug in the scheme. Statistics show that 201,000,000 prescriptions had been dispensed for national health service patients in England and Wales last year—about a half pint of mixture for every man, woman and child in the country.

MEDICAL SOCIALIZERS HIT BELOW BELT AGAIN

Look out for more below-the-belt punches by Socialized Medicine advocates of the Democratic National Committee! Here's what happened in one state:

Minnesota newspapers carried photographs showing wounded American soldiers in Korea with superimposed headlines such as, "Financial Help Now Essential To Nation's Medical Schools"; "15 of 3,000 Doctors Answer Army Call," and the like.

Doctors were dumbfounded when they looked at the credit line and found "Wide World Photos" —an ethical news photo service operated by the Associated Press. The medical profession traced the origin with the help of Wide World and found the photos were in truth Wide World pictures but that the Democratic National Committee had added its own propaganda.

Wide World in a letter to the A. M. A. wrote: "Use of the picture in the manner in which you saw it printed was not authorized by Wide World. We took up the matter immediately with representatives of the Democratic National Committee which improperly handled the publication. The organization sent out a notice to kill the photo credit."

"The ... estrogen preferred by us is 'Premarin,' a mixture of conjugated estrogens, the principal one of which is estrone sulfate."

Hamblen, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

In treating the menopausal syndrome with "Premarin," Perloff* reports that "Ninety-five and eight tenths per cent of patients treated with 3.75 mg. or less daily obtained complete relief of symptoms"; also, "General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin,'"

Thus, the sense of "well-being" usually imparted represents a "plus" in "Premarin" therapy which not only gratifies the patient but is conducive to a highly satisfactory patient-doctor relationship.

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg. and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

ACCEPTED Council on Pharmacy and Chemistry of the American Medical Association

*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens...estradiol, equilin, equilenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.

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Henderson Answers C. I. O. . . .

Charges in Paid Advertisements that Profession Opposed Progress in Medicine and Health Are Branded as False by A. M. A. President

THE C. I. O. National Health Committee—whatever that is—used more than 1,000 words in a paid advertisement appearing in a number of newspapers during the week of October 22 to tell doctors that it did not like the American Medical Association's national advertising campaign against socialized medicine. The advertisement, headed "Dear Doctor," evidently appeared in newspapers in cities where a C. I. O. candidate was running for office on a platform to support the administration's compulsory health insurance plan.

A. M. A. President Elmer L. Henderson replied to the ad in a two-page article appearing on pages 933 and 934 in the November 11 issue of *The Journal of the American Medical Association.*

The advertisement, which bitterly denounced the A. M. A. and nearly everything for which it stands, was, Dr. Henderson said, "the same old fancy-wrapped package of lies, untruths, half-truths and part-truths—all aimed at confusing the American people on the issue of socialized medicine."

Dr. Henderson said in his reply that the public, in reading the advertisement, naturally did not know that nearly the entire text was taken from a speech which Rep. Andrew J. Biemiller, Democratic representative from Milwaukee, made before Congress and which was printed in the Congressional Record.

Incidentally, Biemiller was defeated on November 7.

Following is Dr. Henderson's statement in part:

Congressman Biemiller as we all know, has sung the praises of socialized medicine for a long time; yet in 1937 and again in 1939, he failed to sell such a scheme to the people of Wisconsin. He once managed the Midwest campaign of Norman Thomas, a Socialist candidate for President, and a Republican officeholder referred to him during the present campaign as "the man who came sailing out of Eastern universities to Wisconsin as the socialist educational director for Milwaukee County."

In a sense, therefore, the advertisement was written by Congressman Biemiller, who gave the American Medical Association a lashing on several points, saying the Association and its state and local medical societies: Opposed vaccination against diphtheria and other contagious diseases by public health authorities; fought against the reporting of communicable diseases and public health services to control tuberculosis and they still oppose free diagnostic centers for tuberculosis and cancer; fought against setting up free venereal disease clinics; fought workmen's compensation laws; fought group medical practice; fought the American Red Cross blood bank plan; fought voluntary insurance plans; and fought many other projects.

His charges are outright lies. Neither he nor those responsible for preparing the advertisement took the time or trouble to ascertain the truth. Evidently, the propagandists had only one objective in mind; to fool the American people.

IMMUNIZATION

The truth of the matter is that the House of Delegates, the policy-making body of the American Medical Association, never opposed vaccination against diphtheria or against any other contagious disease. And it never fought against the reporting of communicable diseases and public service health services to control tuberculosis. In fact, the House in 1925 urged periodic health examinations for the general public, and in 1937 it adopted a resolution urging that "every effort be made to promote all features of preventive medicine, including diphtheria and all communicable diseases, and to make these features available to the public." That certainly does not smack of opposition.

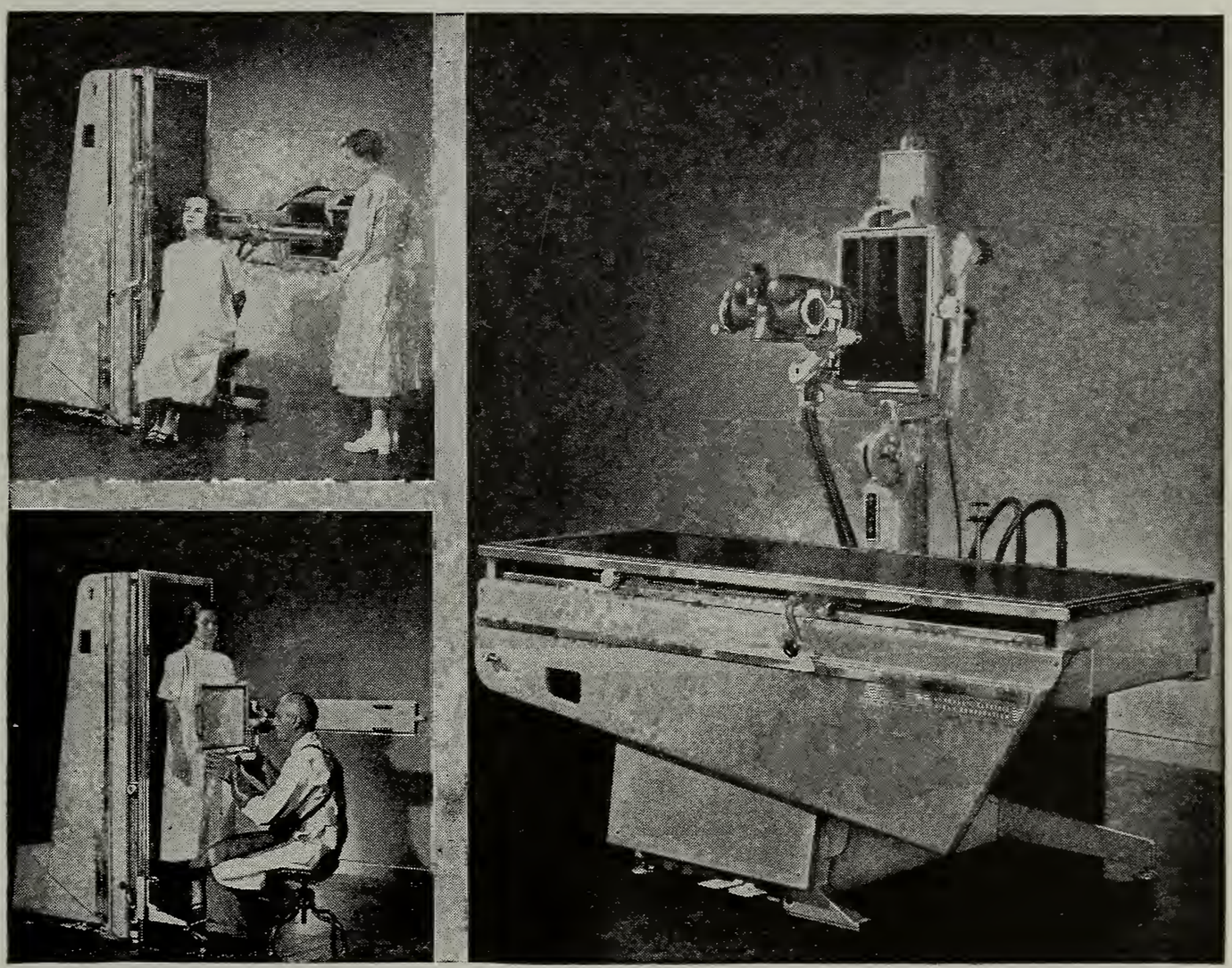
CANCER AND TUBERCULOSIS

In his wild reference pertaining to cancer and tuberculosis control, Mr. Biemiller did not trouble himself to check the resolution, passed by the House back in 1905, which commended the "American Society for the Control of Cancer" for its program of public education on detection and prevention of cancer. Nor did he bother to delve into the fine work which the Woman's Auxiliary to the American Medical Association has done since its founding in 1922 to prevent and eradicate tuberculosis, especially among children. His comments about venereal disease clinics are ridiculous. In 1937—13 years ago—the House adopted a resolution recommending special venereal disease divisions in health departments and use of hospital and dispensary clinics for early treatment and follow-up.

WORKMEN'S COMPENSATION

It might interest Mr. Biemiller to know that the Association never opposed the principle of workmen's compensation legislation. Any state-

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Resident Representative:
DAYTON — C. H. Cross, 1116 Linden Avenue

ment to that effect is a deliberate untruth, aimed to mislead the American working man. During the formative period of this legislation, the American Medical Association did contend that there were certain inadequate provisions for the supplying of medical care to injured workmen, and pointed particularly to the absence of any right given to the injured workman to select his own physician. That stand of the Association was to protect the working man and not to challenge any benefits he might receive. As Dr. William D. Haggard, president-elect of the Association in 1925 said, "The denial of the right of the patient to choose his own physician or surgeon when injured is un-American, unwise and one step toward state medicine."

GROUP PRACTICES

Mr. Biemiller said, too, that the American Medical Association fought group practice. The statement actually is silly, because three Mayo Clinic physicians have served as presidents of the Association, and at least three members of its Board of Trustees are connected with such clinics. Dr. William Mayo served as president in 1906, Dr. Charles Mayo in 1916 and Dr. E. Starr Judd in 1931. All three were connected with the best known group practice clinic in the world.

The American Medical Association has consistently fought for the highest type of standards in group practice. When any group practice plan was tied in with a questionable insurance scheme or when a patient was restricted to a particular group of doctors by his insurance policy or when any group practice plan restricted a patient in the free choice of a physician, the Association was never hesitant in voicing bitter objection. This was done in the sole interest of better medical care for the patient. The attitude of the American Medical Association toward group practice is plainly revealed in a section of its "Principles of Medical Ethics," which says, "The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual."

RED CROSS

Mr. Biemiller made his caustic reference to the American Medical Association and the American Red Cross Blood Bank plan even though the American Medical Association's House of Delegates had gone on record as endorsing the idea of a national blood procurement program under auspices of the Red Cross. Furthermore, when the Red Cross Blood Bank plan was first conceived—even before it was publicly announced—the Board of Trustees of the American Medical Association approved it in principle. If Mr. Biemiller had investigated first, he would have learned also that the Association, at considerable cost to member doctors, made the only comprehensive survey of blood banking in the United States.

VOLUNTARY HEALTH INSURANCE

For Mr. Biemiller to imply that the American Medical Association opposed voluntary health insurance plans of the type available today is a deliberate falsification of facts. Fifteen years ago, the Association did oppose some of the so-called voluntary health plans, but for good reason. Certain features were objectionable, and they have long since been eliminated thereby helping to speed up the growth of the strong voluntary health plans as they exist today. Today, the total number of persons protected by all types of hospitalization and medical care insurance exceeds 70,000,000, a remarkable figure when one considers that the total only five years ago was 26,000,000.

FEDERAL AID TO MEDICAL SCHOOLS

Mr. Biemiller said, too, that the American Medical Association "blocked Federal aid to medical schools." He is right, but he failed to explain that the bills proposed would lead to control of the medical schools by the Federal government either directly or indirectly with a gradual deterioration of medical education because of political domination. The Association long has held that the problem of financial support for medical schools should be freely in the hands of the communities or states served by these schools.

NOTHING IS FREE

The advertisement inspired by Mr. Biemiller's speech said that, since "the cost of medical care is too high for anyone except the wealthy, the people want to pool their resources to meet a common risk." What the advertisement failed to tell union men is that under whatever method a worker's medical care is paid, he himself eventually will have to pay the bill.

If the bill comes from Uncle Sam, it will be a tax bill and there will be no escaping it. It will be a stiff bill, too, because it will have added to it all the lost motion, waste and inefficiency that goes with government management in any big business. Added to the worker's medical costs will be the salaries and maintenance of administrators, accountants and supervising physicians, as well as the costs of accounting machinery and the necessary buildings to house the records. The worker certainly will be subject to all the disadvantages of deteriorating medical care at a high price.

By placing such an advertisement in newspapers, those responsible for it showed that they have lost all sense of fair play. As a union, the C. I. O. believes that every member has a right to have something to say about the conditions under which he works. Doctors have as much

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right as the coal miner, the steel worker, the railroad man or any other person to have a voice in determining the conditions under which they work. They, as Dr. W. W. Bauer said in his recently published book, *Santa Claus, M. D.*, especially are entitled to this privilege because of the safeguards their profession believes is necessary for the welfare of the patient. Yet, through what is advocated in the advertisement, impossible conditions would be imposed on the 200,674 physicians in the United States. This is dishonest, unfair and contrary to all American principles and contrary to what members of a union themselves fight for.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since September 1, 1950. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

AUGLAIZE COUNTY
David W. Nielsen, Waynesfield

CLARK COUNTY
H. M. Tardif, Springfield

CUYAHOGA COUNTY
Bernard L. Brofman, Cleveland
Peter J. Corrigan, Jr., Cleveland
Thomas I. Crawford, Cleveland
Richard G. Deucher, Cleveland
William J. Donaldy, Cleveland
A. E. Handy, Jr., Cleveland
Robert A. Hays, Cleveland
Joseph C. Jenkins, Cleveland
Louis J. Jindra, Cleveland
John W. King, Cleveland
William J. McGannon, Cleveland
Jack Meltzer, Cleveland
Pierce H. Mullally, Cleveland
Alexander P. Orfirer, Cleveland
Arthur J. Patek, Jr., Cleveland
Robert H. Perchan, Cleveland
John R. Reed, Cleveland
Ausey H. Robnett, Cleveland
Donal R. Ross, Bay Village
Harry M. Wildblood, Cleveland
Charles G. Zegiob, Cleveland
R. J. Zwalsh, Cleveland

DELAWARE COUNTY
William D. King, Delaware

FAYETTE COUNTY.
Byers W. Shaw, Washington C. H.

FRANKLIN COUNTY
Beatrice Bamberger, Columbus
Robert I. Barickman, Jr., Muncie, Ind.
Roderick A. Bryce, Columbus
William O. Duggar, Columbus
John Shiu Fung, Columbus
Robert A. Heilman, Columbus
Torrence A. Makley, Jr., Columbus
James Richard Monroe, Columbus
Darwin K. Phelps, Columbus
Robert Jones Rohn, Indianapolis, Ind.
Gerald G. Schreiber, Columbus
Joseph P. Whitlatch, Columbus

HAMILTON COUNTY
Sanford Blank, Cincinnati
Gordon L. Block, Jr., Cincinnati
Cornelius B. DeCourcy, Cincinnati
Leonard Gottesman, Cincinnati
Ralph S. Grace, Cincinnati
Frederick D. Haffner, Cincinnati
Edward Hartenian, Cincinnati
Helen L. Jackson, Cincinnati
Roy T. Johnson, Jr., Cincinnati
Sol Kessel, Cincinnati
John A. Kirchner, Cincinnati
Harry J. Konerman, Cincinnati
Frederick V. Kristoff, Cincinnati
Clifford E. McIntyre, Cincinnati
John F. Miley, Cincinnati
Frank Princi, Cincinnati
William Ransohoff, Cincinnati
Samuel A. Trufant, Cincinnati
John C. Willke, Cincinnati
John P. Wissinger, Cincinnati

HARDIN COUNTY
William T. Ellis, Dunkirk

LAWRENCE COUNTY
Harry Nenni, Ironton

LOGAN COUNTY
Robert H. Lanfersieck, Quincy

LORAIN COUNTY
Charles J. Cooley, Oberlin
William H. Miller, Jr., Elyria
John W. Wherry, Elyria
Richard M. Wilke, Lorain

LUCAS COUNTY
Philip Cohn, Toledo
Arthur M. Dalton, Toledo
Marian M. Rejent, Toledo
Kenneth Schoenrock, Toledo

MARION COUNTY
James A. McGlew, Marion
Richard W. Mills, Marion
Frank V. Murphy, Jr., Marion

MIAMI COUNTY
Gerard F. Wolf, Piqua

MUSKINGUM COUNTY
John Q. Adams, Zanesville

PICKAWAY COUNTY
Ray Carroll, Circleville
Mark H. Huckeriede, Circleville

PUTNAM COUNTY
James L. Goddard, Kalida
James B. Overmier, Leipsic

SENECA COUNTY
Thomas D. Efstation, Tiffin

SUMMIT COUNTY
Clinton S. Bond, Akron
Albert H. Bremer, Stow
George W. Duffey, Akron
Louis A. Lame, Cuyahoga Falls
Charles K. Wintrup, Akron
John L. Zintsmaster, Akron

New Doctor Film for Schools Is Available

A new film, "Your Friend, the Doctor," was released recently by Coronet Instructional Films, Inc., Chicago. Fred V. Hein, Ph. D., and Dr. Donald A. Dukelow, of the A. M. A. Bureau of Health Education, served as consultants in the development of the film, which is intended for use in primary and intermediate grades (first to sixth).

The film portrays the role of the family physician in the school and home and stresses his friendly guardianship of child and family health. The film is available in both color and black and white, and will soon be available to schools from state and local health and education departments.

Local medical societies may obtain the film from Coronet Films, Inc., 65 E. South Water St., Chicago. Screening of this 16 mm. film before parent-teacher groups and others concerned with family-school-physician relations is desirable from the public relations standpoint, the A. M. A. advises.

Rural Health Conference Scheduled in Memphis

The sixth annual National Conference on Rural Health will be held in Memphis, Tenn., February 23-24. It will be sponsored by the Committee on Rural Health of the American Medical Association in cooperation with national farm organizations.

More than 700 farm and health leaders, including representatives of health and farm groups, farm newspapers, agricultural extension organizations, rural health committees, schools, public health officials and others, are expected to attend. Sessions will be held in the Peabody Hotel.

State rural health committee chairmen will hold a preliminary meeting on February 22, the day before the conference opens.

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Hospital Building Curtailed . . .

U. S. Budget Cut May Materially Affect Construction in Ohio Unless Congress Takes Steps To Restore Appropriations Formerly Approved

CURTAILMENT of hospital construction in Ohio during the next 18 months is inevitable unless Congress takes action to restore drastic cuts ordered by the U. S. Department of the Budget in Federal appropriations made under the Hill-Burton Act.

This situation was considered at a recent meeting of the Ohio Hospital Advisory Council to the Division of Hospital Facilities, State Department of Health.

It had been anticipated that Ohio would have $6,000,000 a year in Federal funds for the fiscal years, June, 1950, to July, 1951, and June, 1951, to July, 1952; also, approximately the same amount for the fiscal year starting in June, 1953.

Long range planning on this basis was done by the hospital facilities division and by applicants. Federal grants-in-aid to many potential applicants were promised and some planning started.

Because of the cuts made by the Federal Government amounting to about 50 per cent, the division has been forced to establish a special priority of hospital projects, some of which have been started; others in the preliminary planning stage.

New factors which were taken into consideration were: bed needs met, funds available, readiness to construct, value to emergency, expenditures incurred to date, etc.

The following projects were determined to qualify for immediate assistance under funds available for the present fiscal year, June, 1950, to July, 1951: Hardin Memorial Hospital, Kenton; Chillicothe Hospital; Cuyahoga County Chronic Disease Hospital; Williams County Joint Township Hospital, Montpelier; Timken Mercy Hospital, Canton; Toledo Health Center; St. Charles Hospital, Toledo; Columbus Health Center; Mercy Hospital, Mt. Vernon; St. Elizabeth Hospital, Dayton, and Citizens Hospital, Barberton.

Approximately $2,000,000 of next year's funds will have to be used to make possible the completion of the foregoing projects.

The following Ohio projects which have been approved for grants-in-aid or are in a stage of planning that will guarantee approval, will be given assistance in the order mentioned as rapidly as additional funds are made available by the Federal Government:

South Unit, Youngstown; Peoples, Akron; Aultman, Canton; Newark City; St. Elizabeth, Youngstown; Good Samaritan, Dayton; Mercy, Canton; Jackson; Miami Valley, Dayton; Fairview Park, Cleveland; Massillon City; Barnesville; Bellaire; Martins Ferry; Van Wert; Findlay; East Liverpool; Bethesda, Zanesville; Good Samaritan, Zanesville; Marion; Middletown; Ft. Hamilton, Hamilton; Green Cross, Akron; Jewish, Cincinnati; Mt. Carmel, Columbus; St. Ann's Columbus.

Some interesting data on the hospital building program nationally were complied recently by the Washington Office of the American Medical Association, as follows:

From the start of the program in 1948 and up to September 1, 1950, the Federal government had given final and binding approval to 1,091 projects, where the Federal share totaled $261,000,000.

Payments through September totaled $91,430,872. It is estimated that total payments by the end of the current fiscal year will be close to $250,000,000, a binding obligation for which Congress has or will make appropriations.

Smaller towns are getting more hospitals, but bigger towns and cities more money. Specifically, 65 per cent of the general hospital projects are in communities of less than 10,000 population, but these get less than 45 per cent of the money.

About 43 **per cent** of all general hospital projects under the program are of 50 beds or smaller, but bigger hospitals are receiving 80 **per cent** of the money.

Money is not going to smaller towns, mainly, because residents either don't want to sponsor hospitals or can't demonstrate they would be able to maintain them once built.

Dermatologists To Meet In Chicago, December 2-7

The ninth annual meeting of the American Academy of Dermatology and Syphilology will be held in Chicago from Saturday, December 2 through Thursday, December 7, Dr. John E. Rauschkolb, Cleveland, secretary-treasurer, announced. Principal sessions will be held at the Palmer House.

Among those taking part are the following Ohio physicians, all of Cleveland: Dr. Clyde L. Cummer, in charge of technical exhibits; Dr. Herbert Z. Lund, and Dr. John R. Haserick who will present scientific papers. Dr. Earl W. Netherton, also of Cleveland, is assistant secretary-treasurer.

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A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; witnessing operations; ward rounds; demonstration of cases; pathology; radiology; anatomy; operative proctology on the cadaver.

For Information Address

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In Memoriam . . .

John R. Buchanan, M. D., Youngstown; State University of Iowa College of Medicine, 1925; aged 49; died October 19; member of the Ohio State Medical Association and a Fellow of the American Medical Association; diplomate of the American Board of Pediatrics. Dr. Buchanan began practice in Youngstown in 1924. In addition to his professional practice, he was active in several organizations among which were the Unitarian Church, the Elks Club and the Youngstown Club. Surviving are his widow, a son, a daughter, two sisters and three brothers.

George L. Chapman, M. D., Toledo; Miami Medical Colege, Cincinnati, 1899; aged 79; died October 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Chapman began his practice in Toledo upon completion of his education and continued until his retirement about two years ago. During World War I, Dr. Chapman served overseas in the Army Medical Corps. He was a member of the Presbyterian Church. Surviving are his widow, a son and a brother.

John Corliss Evans, M. D., Mt. Airy; Eclectic Medical College, Cincinnati, 1893; aged 78; died October 9 as the result of a traffic accident. Dr. Evans had been surgeon for the New York Central Railroad for approximately 37 years. His widow and a son survive.

Arthur B. Hobson, M. D., Salem; University of Wooster, Medical Department, Cleveland, 1895; aged 79; died October 27; member of the Ohio State Medical Association and the American Medical Association through 1948. Dr. Hobson moved his practice from Cleveland to Salem in 1908 and continued active until 1938 when he went into semi-retirement. Last year he was presented the 50-Year Pin and Certificate of the Ohio State Medical Association through the Columbiana County Medical Society. He was trustee in the Methodist Church. Three brothers survive.

Jonah L. Hurst, M. D., Dorset; Eclectic Medical College, Cincinnati, 1902; aged 72; died October 31; member of the Ohio State Medical Association and the American Medical Association. In addition to his private practice, Dr. Hurst was active for many years in health work. He was a member of the Ashtabula County Health Board, 1932-1935 and health commissioner, 1935-1940. He served for 12 years on the Dorset School Board. Two sons survive.

Gustav A. Jand, M. D., Cleveland; Pulte Medical College, Cincinnati, 1897; aged 78; died October 31. Dr. Jend had served virtually all of his medical career in Cleveland. He was a member of Phi Epsilon Rho and the Methodist Church. Surviving are his widow, a daughter, two brothers and a sister.

David M. Keating, M. D., University Heights; St. Louis University School of Medicine, 1926; aged 52; died October 18; member of the Ohio State Medical Association and the American Medical Association through 1949; vice-president of the Cleveland Academy of Medicine, 1946; delegate 1946. In addition to his practice and many activities in the Academy, Dr. Keating devoted much time to other civic interests, among which was the hospital fund-raising campaign. He was a member of the Catholic Church and the Cleveland Skating Club. Surviving are his widow and a sister.

Henry F. Kenkel, M. D., Cincinnati; University of Cincinnati College of Medicine, 1920; aged 46; died October 16; member of the Ohio State Medical Association and the American Medical Association through 1948. Dr. Kenkel practiced medicine in the north side of Cincinnati for 24 years before retiring about six years ago because of his health. He was a member of the Catholic Church.

Charles Louy, M. D. Toledo; Toledo Medical College, 1897; aged 81; died October 21; member of the Ohio State Medical Association and the American Medical Association through 1942. Dr. Louy had practiced for more than 50 years in Toledo, and last year was presented the 50-Year Pin and Certificate of the Ohio State Medical Association by the Academy of Medicine of Toledo. During World War I, he served in the Army Medical Corps. He was a member of the Catholic Church, the Elks Club, the American Legion, Ephoneta Auxiliary, Catholic Knights of America, and the Holy Name Society. Surviving are his widow, a sister and a brother.

John F. McHugh, M. D., Shelby; University of Louisville School of Medicine, 1921; aged 53; died October 24 as the result of a traffic accident while in the East; member of the Ohio State Medical Association and the American Medical Association; secretary-treasurer of the Richland County Medical Society, 1942-1943 and its president in 1944. Dr. McHugh had practiced in Shelby beginning in 1926. He was a member of the Catholic Church and a past commander of the Knights of Columbus. Surviving are his widow, two daughters, a son, his mother and two sisters.

Robert H. McKelvey, M. D., Salem; Ohio State University College of Medicine, 1933; aged 45;

died November 2; member of the Ohio State Medical Association and the American Medical Association. Dr. McKelvey moved to Salem from Bethesda 12 years ago. He was a member of the Medical Corps during World War II. A daughter survives.

Wayland B. Recker, M. D., Leipsic; St. Louis University School of Medicine, 1926; aged 48; died October 29; member of the Ohio State Medical Association and a Fellow of the American Medical Association; secretary-treasurer of the Putnam County Medical Society, 1929; vice-president, 1934 and 1937; president, 1939; delegate, 1948 and 1950; past-president of the Northwestern Ohio Medical Association; member of the American Association of Railway Surgeons. Dr. Ricker had practiced medicine in Leipsic for 24 years. He was on the staffs of St. Rita's Hospital of Lima and the Lima Memorial Hospital. Activities in medical profession work included membership on the Committee on Rural Health of the Association. He was a member of the Catholic Church and the Knights of Columbus. Surviving are his widow, one son and three daughters, his father and three brothers.

George Washington Stober, M. D., Shaker Heights; Ohio State University College of Homeopathic Medicine, 1918; aged 56; died November 2; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Stober had been health director for East Cleveland for approximately 30 years. For many years also prior to 1947 he had been school physician in the area. He was the author of a number of medical articles, especially in the field of gastro-enterology. Surviving are his widow and two daughters.

Edward von den Steinen, M. D., Tucson, Ariz.; Western Reserve University School of Medicine, 1905; aged 74; died October 10; member of the Colorado State Medical Association and the American Medical Association. Dr. Von den Steinen was director of physical education at Western Reserve University from 1903 to 1920, before going to Colorado. Surviving are a son, a daughter, a brother and two sisters.

A competitive examination for appointment of Medical Officers in the Regular Corps of the U. S. Public Health Service will be held February 12-14. Applications must be in by January 15. Additional information may be obtained by writing the Surgeon General's office, Division of Commissioned Officers.

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Additional facilities for pre-medical training at Ohio Wesleyan University, Delaware, will be provided by the Edward L. Rice Pre-Medical Fund established by Dr. John E. Brown, Columbus, as a tribute to Professor Edward L. Rice, head of the zoology department for 45 years. Dr. Brown graduated at O. W. U. in 1884.

* * *

Dr. Karl E. Kimber, chief of professional services of the Veterans Administration Hospital, Brecksville, is the new president of the Ohio Tuberculosis Hospital Association. Dr. James Villani, superintendent of Edwin Shaw Sanatorium, Akron, is the secretary-treasurer.

* * *

Dayton physicians were guests of the Miami Valley Pharmaceutical Association at a banquet, November 1, at the Hotel Biltmore. Mr. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, was the speaker.

* * *

Driver's license in New Jersey next year will note holder's blood type, in case he needs quick transfusion after atomic disaster.

* * *

U. S. doctors collected $2,267,000,000 for services in 1949, or about 1.2 per cent of all money spent on personal goods and services, reports Department of Commerce.

* * *

More than three-fourths of the pharmacists responding to a recent poll favor the voluntary medical care plans, while only nine per cent favor a government-sponsored plan, according to *American Druggist*.

* * *

The subscription price of *The Journal of the A. M. A.* will be increased from $12 to $15 effective in January. The Board voted not to increase the special rate to students and others, which was put into effect last February.

* * *

Fellowship dues of the American Medical Association have been set at $5 per year by the Board of Trustees. Those Fellows who enter military service after the end of 1950 will be required to pay Fellowship dues for the half year in which they go into service, but not thereafter while they are in service.

* * *

The Ohio Department of Health and the U. S. Public Health Service is cooperating with local authorities in studying the poliomyelitis epidemic in Paulding County. The county of about 15,000 population had 32 cases in a period of about two months.

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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

HAMILTON

Speaker at the Nov. 14 meeting of the Academy of Medicine of Cincinnati was Dr. DeWitt Stetten, Jr., chief of the Division of Nutrition and Physiology of the Public Health Research Institute of the City of New York, whose subject was "Fat and Carbohydrate Stores in Experimental Diabetes." A joint meeting was held with the Diabetes Council.

At the Nov. 28 meeting, Dr. Brian B. Blades, professor of surgery, George Washington University School of Medicine, Washington, D. C., spoke on "The Practical Application of Recent Advances in Thoracic Surgery."

Coming meetings will feature the following programs:

Dec. 5—"Functional Patterns in Renal Disease: Clinical and Therapeutic Correlations," Dr. Arthur C. Corcoran, Cleveland Clinic Foundation.

Jan. 9—"Newer Clinical Knowledge Regarding ACTH," Dr. John R. Mote, Armour Laboratory, Chicago.

Jan. 23—"A Plea for the Stethoscope," Dr. Samuel A. Levine, Harvard Medical School, Boston (The Alfred Friedlander Lecture); a joint meeting with the Heart Council.

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CLARK

Dr. Frank H. Mayfield, Cincinnati, discussed "Management of Acute Head Injuries" at the Oct. 16 meeting of the Clark County Medical Society. The scientific program was sponsored by the Committee on Trauma of the American College of Surgeons, Southwestern District of Ohio.

GREENE

Dr. Robert A. Lyon, associate professor of pediatrics, University of Cincinnati College of Medicine, and one of the founders of the Children's Heart Association, spoke on the subject, "Heart Disease in Children and Rheumatic Fever," at the Nov. 9 meeting of the Greene County Medical Society in Xenia. His talk was illustrated by the use of slides.

At the Oct. 12 meeting of the Society, Dr. Hans G. Schlumberger, Department of Pathology, Ohio State University College of Medicine, spoke on the subject of bone-producing lesions of the scalp, skull and brain.

The following members were appointed a committee to conduct a diabetic survey of school children as a part of the observance of National Diabetic Week: Dr. Ernest Hoffman, Yellow Springs; Dr. Harvey McClellan, Xenia; and Dr. C. K. Schloss, Fairborn.

MIAMI

The regular meeting of the Miami County Medical Society was held on Nov. 3 at the Nurses' Home of Stouder Hospital, Troy. Dr. Irving Rothchild, Ohio State University College of Medicine, Columbus, spoke on the subject, "Endocrinology—a Help or a Hindrance to the General Practitioner." Dinner was served at the hospital following the meeting.

A new series of radio programs sponsored by the Society over Station WPTW, Piqua, began on Nov. 4. It is entitled "The Story Behind the Discovery," and is broadcast each Saturday at 10:30 a. m. A special broadcast was made on Sunday, Nov. 5, entitled, "The Wooden Fish."

MONTGOMERY

At a meeting of the General Practice Section of the Montgomery County Medical Society on Oct. 25, Dr. Smith Freeman and Dr. David Markson, Northwestern University Medical School, presented a program on ACTH and Cortisone. Dr. Allan S. Horwitz, section president, was in charge.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

DEFIANCE

The Defiance County Medical Society sponsored a luncheon on Oct. 10 at the Kettering Golf Club in Defiance, at which U. S. Public Health Service physicians and technicians discussed findings concerning the epidemic of poliomyelitis in nearby counties. Doctors of the surrounding counties were guests.

LUCAS

The program of the Academy of Medicine of Toledo and Lucas County for October was as follows:

General Meeting, Oct. 6—Panel Discussion—William Roche Hospital.

Section on Pathology, Experimental Medicine and Bacteriology, Oct. 13—"Localized Enlargement of the Thyroid," Dr. John B. Hazard, Cleveland Clinic.

General Practice Section, Oct. 17—No meeting because of meeting of Northwestern Ohio Medical Association.

Medical Section, Oct. 20—"Clinical Experiences

with ACTH," Dr. John E. Howard, Johns Hopkins University.

Surgical Section, Oct. 27—"A New Technic for the Excision and Transplantation of Split Skin Grafts," Dr. John D. Reese, Philadelphia, Pa.

COLUMBIANA

Dr. Arthur G. James, Ohio State University College of Medicine, Columbus, spoke on "Cancer of the Face and Neck," at the Sept. 19 meeting of the Columbiana County Medical Society.

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

LAKE

The Lake County Medical Society met Nov. 14 at Lake County Memorial Hospital, Dr. Paul Reading, president, presiding. The Mental Hygiene Committee reported that the psychiatric examination service by Dr. F. E. Merritt, of Cleveland, each Thursday at the Hospital has been eminently successful. Probably more hours will have to be added because the demand for service has been so great, the committee reported. The Public Relations chairman reported that the physicians' call bureau sponsored by the Society has been functioning to the public's satisfaction.

The following officers and delegates were elected for 1951: Dr. Thomas Byrne, Menta, president; Dr. Keeth Miles, Madison, vice-president; Dr. G. Robert Smith, Painesville, secy.-treas.; Dr. M. G. Carmody, Painesville, delegate; Dr. B. S. Park, Painesville, alternate; and Dr. C. B. Elliott, Painesville, censor.

Dr. Robert Eiben, director of contagious diseases at City Hospital, Cleveland, was introduced by the program chairman, Dr. Thomas Byrne. Dr. Eiben spoke on "Poliomyelitis."—F. J. Dineen, M. D., Pub. Relations Chairman.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

Mr. Matthew Curry, local director of welfare, spoke on "Problems in Welfare Department Work in Columbiana County," at the Oct. 17 meeting.

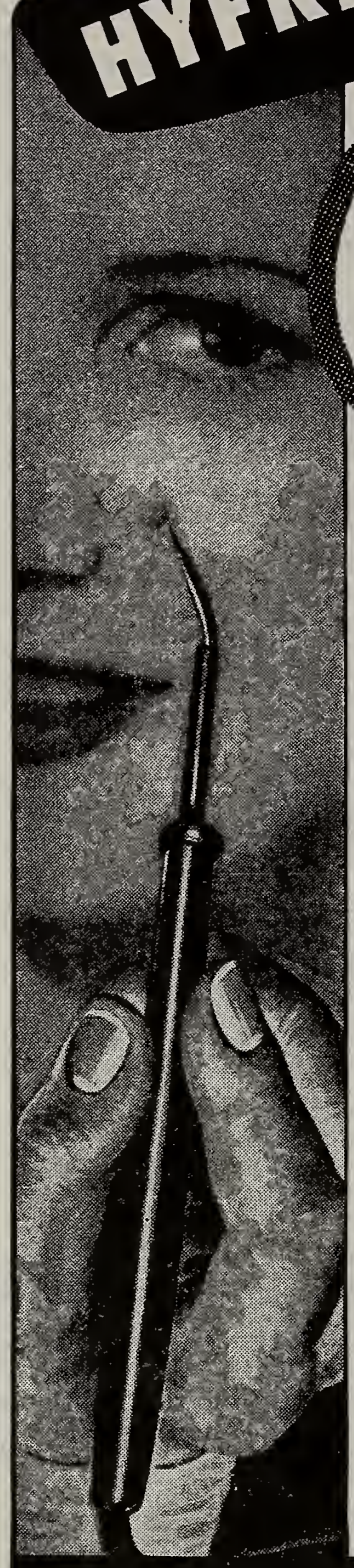
MAHONING

Dr. Marion A. Blankenhorn, University of Cincinnati College of Medicine, spoke on the subject "The Spotted Fevers," at the Sept. 19 meeting of the Mahoning County Medical Society in Youngstown. At a previous meeting of the Society's Council, applications for active membership were acted upon favorably for Dr. Harold Teitelbaum and Dr. Francis J. Gambrel.

Speaker for the Nov. 14 meeting was Dr.

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Howard F. Root, physician-in-chief, Deaconess Hospital, Boston, Mass., and past-president of the American Diabetes Association, whose subject was "Medical and Surgical Treatment of Diabetes."

STARK

Dr. Alan R. Moritz, professor of pathology, Western Reserve University, School of Medicine, Cleveland, spoke on the subject, "Fatal Non-Penetrating Injuries of the Head, Neck and Body," at the Nov. 9 meeting of the Stark County Medical Society in Canton. The annual business meeting of the Society will be held at the Hotel Onesto at 8:30 p. m. on Dec. 14.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

Dr. William M. Sheppe, Wheeling, W. Va., spoke on the subject of diabetes with special reference to NPH-50 insulin at the Oct. 26 meeting of the Belmont County Medical Society at the Belmont Hills Country Club. Other matters discussed were a cancer clinic for the county and the qualifications of candidates for public office.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M. D., LANCASTER)

GUERNSEY

The regular meeting of the Guernsey County Medical Society was held with luncheon at the Berwick Hotel, Cambridge, on Nov. 2, with 12 members present and Dr. Reo Swan, president, in the chair.

The Society was favored with a visit from Dr. Chester P. Swett, Lancaster, Councilor of the Eighth District of the Ohio State Medical Association, who spoke comprehensively regarding many subjects discussed at the September meeting of The Council of the O. S. M. A. (Minutes of this Council meeting have appeared since in the November issue of *The Journal.*)

Legislative Committeeman Dr. Robert A. Ringer reported on progess made in interviewing candidates for public office.

The scientific portion of the program was in charge of Dr. James A. Toland who presented a comprehensive color movie with sound on the subject of allergy, produced at the University of Pittsburgh.—Gordon Lawyer, M. D., Sec'y.-Treas.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M. D., COLUMBUS)

FRANKLIN

"Birth Injuries in Retrospect" was the title of a discussion by Dr. Charles F. McKhann, professor of pediatrics at Western Reserve University School of Medicine, at the Nov. 20 meeting of the Columbus Academy of Medicine. The annual Academy banquet and dance was on schedule for Nov. 29 at the Chittenden Hotel.

ROSS

"The Irritable Colon," was the subject discussed by Dr. Samuel W. Robinson, Ohio State University College of Medicine, at the Oct. 19 meeting of the Ross County Academy of Medicine in Chillicothe.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

HURON

The Huron County Medical Society held its regular quarterly dinner meeting on Sept. 29 in Norwalk. The policy of the National Education Campaign of the A. M. A. was presented. Members of the legislative committee presented factual information on candidates in the coming election.

LORAIN

The regular meeting of the Lorain County Medical Society was held on Nov. 14 at the Spring Valley Country Club, Elyria, with dinner. A memorial address for the late Dr. Walter W. Tilock of Lorain who died Oct. 14 was given by Dr. Leonard A. Stack. The remainder of the meeting was devoted to discussion of business and professional matters pertaining to the Society.

Woman's Auxiliary . . .

By MRS. S. L. MELTZER, Chairman, Publicity Committee
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President—Mrs. George W. Cooperrider, 1828 Bryden Road, Columbus

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Recording - Secretary — Mrs. Ross Knoble, 219 - 44th St., Sandusky

Corresponding Secretary — Mrs. Oscar Jepsen, Canal Winchester

Treasurer — Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo 13

Past-President—Mrs. C. W. Kirkland, 4805 Guernsey Street, Bellaire

ALLEN

"Sidelights on San Francisco," presented by Mrs. Carl H. Zinsmeister, featured the program of the Sept. 26 meeting of the Woman's Auxiliary to the Lima and Allen County Academy of Medicine. During the business session, presided over by Mrs. W. B. Light, president, the year's plans—as formulated earlier by the executive board—were presented. Program booklets were distributed and detailed plans for coming meetings were outlined by Mrs. R. L. Tecklenberg, program chairman. Mrs. Karl F. Ritter, historian, reported that books had been placed in

the Lima Public Library in memory of Mrs. Allan Wisely, Dr. W. H. Beery, Dr. John R. Tillotson and Dr. Harvey Basinger. The legislative chairman, Mrs. Miles Flickinger, reported that reminders had been sent to members and doctors who had not yet registered.

Mrs. J. M. McBride was hostess for the meeting, assisted by Mrs. F. G. Maurer and Mrs. Tecklenberg.

The year's money-making event was held on Tuesday, Oct. 17, when the Auxiliary sponsored a "Canasta Fiesta" in the nurses' home at Memorial Hospital. Proceeds from the Fiesta will be used to augment the student nurses' loan fund. At present the group is assisting six nurses at the community's two hospitals—St. Rita's and Memorial. Mrs. J. W. Burke and Mrs. R. G. Hendershot served as co-chairmen.

CLARK

Mrs. E. W. Smith and Mr. P. D. Leveaux shared the stimulating program of the Nov. 1 meeting of the Woman's Auxiliary to the Clark County Medical Society, held at Ker-Deen Inn. Mrs. Smith presented a monologue in costume, entitled "Medicine Marches On"—a characterization of the doctor's wife of yesterday, today, and tomorrow. It also portrayed the story of medicine of those three periods.

Mr. Leveaux, who spoke on "Probable Reasons for the Rise of Socialism in England," based his talk on his own personal experiences. He was a native of England and resided there until eighteen months ago. He spent eight years in the British Army. When asked whether England could return to its former society under a possible new conservative government, he answered, "Now that the damage has been done, England's situation is like an omelet—you can't unscramble it."

Mrs. E. W. Schilke, president, welcomed the evening's guests who included the husbands of members. Mrs. Victor Fredericks, president of the Champaign County Auxiliary, also was present with her husband as was Dr. E. W. Smith of Dayton. Mrs. C. T. Doeing, program chairman, introduced the speakers. The program committee acted as hostesses for the evening with Mrs. Starling Yinger, chairman of the social hour which followed the program.

ERIE

A luncheon at the "Log Cabin Inn" and a fashion show presented in cooperation with the William Frankel Company highlighted the Oct. 9 meeting of the Woman's Auxiliary to the Erie County Medical Society. In addition to the regular members, some 30 guests were also present. During a brief business session conducted by the president, Mrs. E. J. Meckstroth, a report was submitted by the legislative committee chairman, Mrs. Paul N. Squire. Mrs. H. W. Lehrer, pro-

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gram chairman, announced that Nov. 19 had been scheduled as the date and the Business Women's Club the scene of the Auxiliary's tea for all city and county high school senior girls who are interested in nursing. Luncheon hostesses were Mrs. E. C. Alexander, chairman, Mrs. W. F. Burger, and Mrs. Harold Bolman. A musical program was presented by Mrs. Burger and Mrs. Leah Thomas.

GUERNSEY

The Guernsey County Auxiliary held its November luncheon meeting at the home of Mrs. J. D. Knapp. Mrs. O. R. Jones, president, conducted the business session. Mrs. C. A. Craig reported on the Eighth District meeting held in Newark. Mrs. Arthur Thomas was speaker of the afternoon, using "Ceramics" as her topic. She was presented by Mrs. James Toland. The group voted a contribution for the local community chest.

HAMILTON

The Cincinnati Auxiliary held a dessert luncheon on Tuesday, Oct. 17, at the home of Mrs. J. T. Clear. Mrs. A. J. Huesman served as hospitality chairman, assisted by a committee of eleven. Mrs. Leonard Wuest and Mrs. Cyril Schrimpf presided at the tea table. Mrs. Richard D. Bryant, president, conducted the business meeting following the luncheon. She welcomed new members of the Auxiliary who were presented by Mrs. Richard Vilter, membership chairman. Mrs. Dale P. Osborn, program chairman for the day, introduced the speaker, Dr. Clarence A. Mills, who spoke on "Radiant Heating and Cooling at 'Reflection Point'." "Reflection Point" is the recently completed home of Dr. and Mrs. Mills. The doctor has spent many years in research on the effect of climate on health at the University of Cincinnati, where he is professor of experimental medicine in the College of Medicine. His early endeavors in this field were directed toward planning for the comfort of hospitalized patients.

Mrs. Vinton E. Siler, program chairman, announced plans for an all-day excursion to the Eli Lilly Pharmaceutical Laboratories in Indianapolis. It was announced that this would take the place of the regular November meeting.

HURON

The Woman's Auxiliary to the Huron County Medical Society met on Oct. 13, at the Norwalk Country Club for a luncheon and business session. The sponsoring of an essay contest to be held in the senior classes of the parochial and public high schools in the near future was discussed in great detail. Mrs. W. H. Kauffman, president, distributed candies and rubber scrub pads to each member—the moneys from which will be turned into the general fund. It was voted to transfer a sizeable amount from the group's general fund to a separate bank account in order to start a nurses' scholarship fund.

KNOX

Mrs. I. S. Workman was hostess to members of the Knox County Auxiliary at its October meeting. Mrs. C. E. Cassaday, president, conducted the business session which was followed by a non-partisan review of the candidates for election, given by Mr. Stanley Johnson, Jr., local attorney. Refreshments were served by the hostess, assisted by Mrs. George Imhoff, Mrs. Joseph Allman, and Mrs. Cassady.

LAWRENCE

The Woman's Auxiliary to the Lawrence County Medical Society met on Oct. 16, at the home of Mrs. Harry Nenni for a dessert luncheon and meeting. The group voted to endorse the 3.5 mill school levy and agreed to help get voters to the polls on Election Day. The nurse recruitment committee is planning an active spring program. A report of the Ninth District meeting was given. Mrs. Nenni was appointed by the executive board to complete the unexpired term of Mrs. F. R. Stewart, secretary-treasurer, who has resigned. Following the business meeting, which was conducted by Mrs. G. N. Spears, president, Mrs. Vallee Blagg reviewed an article



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from *Today's Health* and discussed the contents of the most recent issue. Information was also given on the rules of the *Today's Health* contest being sponsored by the American Medical Association.

LAKE

The Lake County Woman's Auxiliary held its first meeting of the 1950-51 season at Parrish's Rose Room. The project of a nurses' scholarship was discussed at length as were other possible projects to be undertaken by the group. Mrs. J. W. Davis reported on the state Auxiliary meeting. The Nov. 3 meeting featured Mrs. S. C. Lind, Fifth District director, who was guest speaker.

LICKING

At the dinner meeting of the Licking County Auxiliary held on Sept. 26, at the Hotel Warden, Mrs. William E. Shrontz was appointed general chairman for the Eighth District Medical meeting to be held at Newark on Oct. 5. Twenty-eight members attended the September meeting. Mrs. Donald Sperry and Mrs. Roland Jones, who attended the conference in Columbus for presidents and presidents-elect, gave a resumé of the meeting. They included excerpts from the talk given by State Senator Roscoe Walcutt on "The Business of the Other Fellow." Mrs. L. H. Miller addressed the local group on "Health Service." Plans were made by the Auxiliary for a rummage sale to be held the latter part of October.

Twenty members attended the Oct. 24 dinner meeting of the Licking County group at Hotel Warden. Mrs. Roland Jones, president, presided at the business session and thanked the members for their efforts in helping to make the Eighth District meeting a successful one. It was announced that the November meeting would be held at the home of Mrs. Victor Turner. A casserole dinner was announced to precede what has been termed a "work meeting." The members will make net stockings for the Red Cross, to be sent to the Veterans' Hospital in Chillicothe. Gifts will also be taken so that the veterans will be able to choose gifts to be sent to their families.

LORAIN

The Lorain County Auxiliary met on Oct. 19, at Spring Valley for its monthly meeting, which was presided over by Mrs. Delbert Russell, president. Social service projects for the coming year were discussed. The chief project will be the establishment of a student nurses' scholarship fund. The first step toward the raising of money for this new project was announced as the sponsoring of a play to be presented by the Elyria Theater Guild the latter part of November. The nurses' fund as well as the group's other welfare activities are under the

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MAHONING

Dr. Fred W. Dixon, president-elect of the Ohio State Medical Association, addressed 170 members and guests of the Mahoning County Auxiliary at a luncheon on Oct. 24, at Squaw Creek Country Club. Special guests of the group were the presidents of all the federated women's clubs of Youngstown. This was the first venture of the group into the field of public relations with other women's organizations; seventy-five groups were represented, including the League of Women Voters, the Women's Republican Club and the Women's Democratic Club.

It was the tenth anniversary of the Auxiliary to the Mahoning County Medical Society. Mrs. R. M. Morrison, the group's first president, was especially honored. Dr. Dixon addressed the group on "A Doctor Looks at Socialism." Another feature of the afternoon was observance of World-Wide United Nations Day. Mrs. Paul J. Mahar, vice-president, described the workings of the United Nations and presented a fitting tribute to that important organization. This observance was concluded with a prayer for peace. The speaker's table was arranged with miniature flags of the United Nations and a floral plateau in our national colors.

Mrs. William H. Evans, president, announced that all Mahoning County Medical Society physicians and their wives were one hundred per cent registered. Credit for this fine showing was given to the diligent efforts of the public relations chairman, Mrs. Ashar Randall, the legislative chairman, Mrs. Herman Ipp, and the committees of both. Mrs. Evans announced that the square dance for the benefit of the nurses' scholarship fund that was held on Sept. 23 was a big success and that it will be continued as an annual event. Each year two girls are selected and sponsored by the Auxiliary—one to train at the Youngstown City Hospital and the other at St. Elizabeth's Hospital.

SCIOTO

The September meeting of the Woman's Auxiliary to the Hempstead Academy of Medicine was held at the home of Mrs. H. M. Keil. Luncheon preceded the business session. Mrs. Clyde W. Everett, president, presided and discussed the Auxiliary plans to assume responsibility for the serving of dinners to those taking part in a horse show benefit for Portsmouth General Hospital to be held that month. Mrs. George W. Obrist, legislative chairman, reported on the doctor draft bill. Mrs. Clyde Fitch was the afternoon's speaker, presenting a stimulating

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talk on "Westward Ho!"—an account of the trip to San Francisco aboard the Ohio State Special. It was announced that the regular October meeting would not be held, because the Scioto Auxiliary would be hostess to the Ninth District Meeting on October 12.

The November 8 meeting was a luncheon for members and guests at the Turkey Shoppe in Portsmouth. Mr. Howard Lee, president of Portsmouth's Little Theater, gave a highly interesting talk on the theater and a detailed explanation of what goes on behind the scenes of a Little Theater movement. Mr. Lee is a talented actor and director. He has also been associated with the Pittsburgh Players.

Mrs. Clyde Everett, president, opened the meeting with a fitting poem, "We Thank Thee for Ohio." Mrs. J. W. Daehler was appointed legislative chairman at the business meeting which followed Mr. Lee's talk. Mrs. Louis Chaboudy and Mrs. Spencer Miller were the day's hostesses.

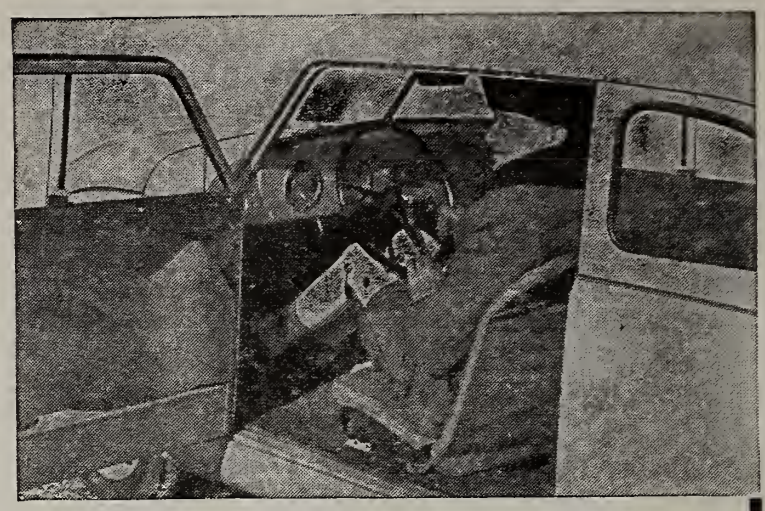
FIRST DISTRICT

The First District of the Woman's Auxiliary to the Ohio State Medical Association met Sept. 26, at the Highland House in Hillsboro. Mack Sauer, of Leesburg, addressed the meeting. His talk was a delightful blend of humor and sound philosophy. Among the special guests in attendance were Mrs. George W. Cooperrider, state president, who also addressed the meeting; Mrs. N. M. Reiff, state public relations chairman; Mrs. Gerald P. Castle, editorial staff of the Ohio State Medical Auxiliary News; Mrs. Paul Woodward, state legislative chairman; Dr. John Anderson, president, Highland County Medical Association, and Mrs. Anderson; Mrs. Richard Bryant, president, Hamilton County Auxiliary; Mrs. Paul Ivins, president, Butler County Auxiliary; and Mrs. J. H. Frame, president, Clinton County Auxiliary.

The district meeting was under the direction of Mrs. Azel Ames, First District director. She was assisted by Mrs. G. B. Glenn, Mrs. W. H. Wilson, Mrs. J. Martin Byers, Mrs. A. M. Brenner, Mrs. J. C. McBride, Mrs. M. Herzberg, Mrs. John McBride, Mrs. J. C. Bohl and Mrs. W. M. Hoyt.

SECOND DISTRICT

The Second District meeting was held in Dayton on Oct. 18 at the Biltmore Hotel. One hundred twenty members attended the luncheon and business session. Mr. Robert Freeman, executive secretary of the Montgomery County Medical Society, spoke on "Politics in Medicine." Mrs. Harold Messenger, Second District director, was in charge of the day's activities. Mrs. George W. Cooperrider, state president, addressed the group. A question and answer period fol-



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lowed. In the evening, the women joined the men for a dinner in conjunction with the Medical Society's Second District meeting.

THIRD DISTRICT

Members of the Woman's Auxiliary to the Marion County Academy of Medicine were hostesses to more than 60 members from nearby counties on Oct. 20 at the Hotel Harding at the fourth annual meeting of Auxiliaries in the Third District. Dr. Fred W. Dixon, president-elect of the Ohio State Medical Association, was the guest speaker. Talks were also given by Mrs. George W. Cooperrider, state president; Mrs. Farrell Gallagher, state president-elect; Dr. Robert T. Gray, president of the Marion County Academy of Medicine; and Mrs. Walter E. Hane, immediate past-president of the Seventh District, Ohio Association of Nurses. Mrs. H. K. Mouser, district director, presided. Dr. Dixon talked on "Political Problems Affecting Medicine Today." Mrs. Cooperrider and Mrs. Gallagher discussed the work of the State Auxiliary and Mrs. Hane spoke on the recruitment of nurses.

Miss Luella Coffalt, contralto, presented a group of musical numbers. Preceding the main part of the meeting, Mrs. Cooperrider and Mrs. Mouser presided over an informal discussion period. The gavel was presented to the Hardin County Auxiliary for having the largest number of members present. Counties represented included Mercer, Auglaize, Hardin, Crawford, Wyandot, Allen, and Marion. Other guests included Mrs. Oscar W. Jepson, state corresponding secretary, and Dr. James Greetham, Dr. Samuel Katz, Dr. Harold K. Mouser, and Dr. William Leffler.

EIGHTH DISTRICT

Forty members and guests were present at the meeting of the Eighth District held on Oct. 5 at the Moundbuilders' Country Club in Newark. Representatives were present from Zanesville, Marietta, Lancaster, and Cambridge. Mrs. Roland W. Jones, president of the Licking County Auxiliary, the hostess group, welcomed the guests at the luncheon. Mrs. O. R. Jones, Eighth District director, conducted the business meeting and introduced the state officials and county officers. Mrs. George W. Cooperrider, state president, told of the worthwhile activities the County Auxiliary had undertaken for the betterment of the community. These included nurse recruitment, contributions to a smaller medical college, furnishing of a room in the local hospital, and send-

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ing worthy nurses for further study in particular fields. Charles Nelson, Executive Secretary of the Ohio State Medical Association, talked on the importance of the coming election and the necessity for every person to vote. He urged the Auxiliary to work for the betterment of the community and to assist in getting the vote out on Election Day.

Later, Mrs. J. Fleek Miller took a number of the guests on a tour of the mounds and Mrs. Ralph Pickett entertained with a social hour in her home before the combined dinner for the Licking County Medical Society, the Auxiliary and guests, at the Moundbuilders' Country Club.

NINTH DISTRICT

The Ninth District meeting was held on Oct. 12, at the Chez Paree in Portsmouth. Members from Scioto and Lawrence Counties attended. Mrs. Clyde W. Everett, president of the local group, gave an address of welcome. The afternoon's business session was presided over by Mrs. George W. Obrist, Ninth District director, Mrs. George W. Cooperrider, state president, discussed the needs, problems, and accomplishments of the local Auxiliaries. A lively question and answer period followed her talk. Mrs. William F. Marting of Ironton, the Ohio Mother of 1950, was the recipient of special honors in an effective tribute by Mrs. Obrist. Following the serving of refreshments, Ollie James, chief editorial writer and columnist with the *Cincinnati Enquirer*, was the afternoon's guest speaker. He presented an hour's program of delightful humor. The women joined the men at a dinner meeting given by the Ninth District Medical Societies.

TENTH DISTRICT

Dr. Arthur S. Fleming, president of Ohio Wesleyan University and chairman of the Ohio Hoover Commission, spoke at the Tenth District annual meeting on Oct. 23, at the Seneca Hotel in Columbus. His subject was "What's Happening to the Recommendations of the Hoover Commission?" Special guests included Mrs. George W. Cooperrider, state president, Mrs. Farrell Gallagher, state president-elect, and Mrs. Oscar W. Jepson, state corresponding secretary. The day's program was under the direction of Mrs. James Snider, Tenth District director. Counties represented were Franklin, Fayette, Ross, Union, Pickaway, Madison, Delaware, Marion and Knox. The Tenth District is 100 per cent organized.

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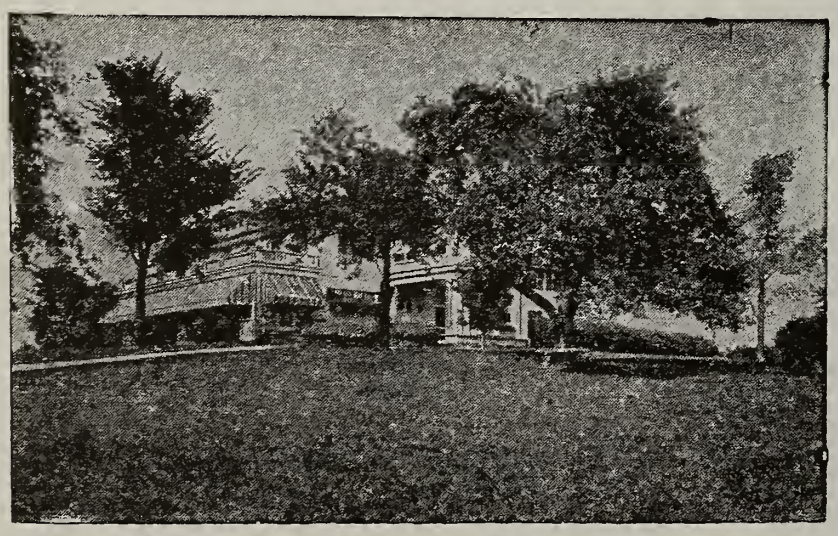
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"Shall We Have Compulsory Health Insurance?" was the topic of a panel discussion during the Ohio Welfare Conference in Columbus, November 14. Participants were: R. Clyde White, Ph. D., Professor of Public Welfare, School of Applied Sciences, Western Reserve University, Cleveland; George H. Saville, Director of Public Relations, Ohio State Medical Association; Leon O. Moscovitz, Technical Assistant, Social Service Department, U. A. W.-C. I. O., Detroit; Ralph W. Jordan, Executive Vice-President, Central Hospital Service, Columbus; James Brindle, Director of Assistance, Pennsylvania Department of Public Assistance, Harrisburg, and Arthur J. Sullivan, Executive Director, Springfield City Hospital. The moderator was Henry J. Robison, Assistant Director, and Coordinator of Social Services, Ohio Department of Public Welfare.

COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Netherland Plaza, Cincinnati, April 24-26, 1951.

A. M. A. Clinical Session, Cleveland, December 5 - 8.

Radiological Society of North America, 36th Annual Meeting, Palmer House, Chicago, December 10-15.

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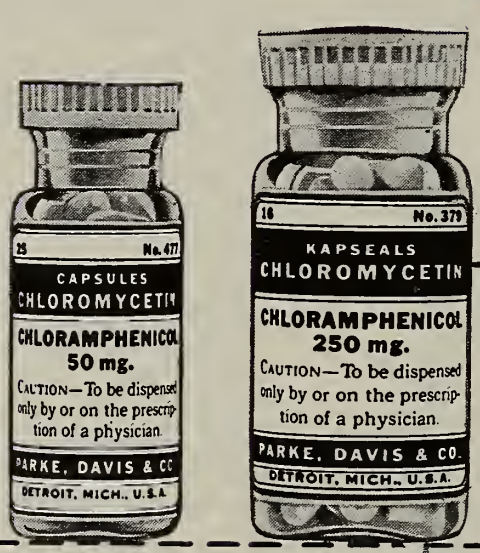
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